114.3 CMR 40.00: RATES FOR SERVICES UNDER M.G.L. c. 152, WORKER'S COMPENSATION ACT

Section

40.01: General Provisions

(1) Scope, Purpose and Effective Date. 114.3 CMR 40.00 shall govern the rates of payment by all purchasers of health care services under M.G.L. c. 152, the Worker's Compensation Act, effective September 1, 2004. 114.3 CMR 40.00 is not authorization for or approval of the substantive services for which rates are determined pursuant to 114.3 CMR 40.00. Program policies relating to medical necessity and clinical appropriateness shall be determined pursuant to M.G.L. c. 152 and 452 CMR 6.00 thereunder.

(2) Coding Updates and Corrections. The Division may publish code updates and corrections in the form of an Informational Bulletin. Updates may reference coding systems including but not limited to the American Medical Association's *Current Procedural Terminology (CPT).* The publication of such updates and corrections will list:
   (a) codes for which only the code numbers change, with the corresponding cross references between existing and new codes;
   (b) deleted codes for which there are no corresponding new codes; and
   (c) codes for entirely new services that require pricing. The Division will list these codes and apply individual consideration (I.C.) reimbursement for these codes until appropriate rates can be developed.

(3) Administrative Information Bulletins. The Division may, from time to time, issue administrative information bulletins to clarify provisions of 114.3 CMR 40.00.

(4) Authority. 114.3 CMR 40.00 is adopted pursuant to M.G.L. c. 118G and M.G.L. c. 152, § 13.

40.02: General Definitions.

(1) Meaning of Terms. Terms used in 114.3 CMR 40.00 shall have the meanings set forth in 114.3 CMR 40.00:

Administrative Costs. A provider's costs for administration including but not limited to facility costs, overhead and costs of doing business are included in the rates set forth in this fee schedule, unless stated otherwise.

At Invoice Cost (AI). The price paid by the provider net of any manufacturer discounts received. Documentation of AI cost must be supplied to purchaser for payment upon request.

Centers for Medicare & Medicaid Services (CMS). A division of the U.S. Department of Health and Human Services (HHS) formerly referred to as Health Care Financing Administration (HCFA) that oversees and publishes rules and guidelines of the Medicaid and Medicare programs.

Codes. 114.3 CMR 40.00 utilizes codes, for which fees are set as defined below:
CPT Codes. Level I coding system of five-digit numeric CPT-4 codes from the Physicians' *Current Procedural Terminology* (CPT) developed and maintained by the American Medical Association. Procedures set forth under 114.3 CMR 40.00 conform to *CPT 2004* codes and descriptors.
HCPCS National Codes. Level II coding system of alpha-numeric codes published and annually updated by the) Centers for Medicare and Medicaid Services (CMS) to supplement CPT codes for medical services and supplies. All D codes are copyrighted by the American Dental Association. Services and items set forth under 114.3 CMR 40.00 utilize *HCPCS 2004* codes and descriptors.

Consultation. A type of service (CPT codes 99241-99275) provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. A physician consultant may initiate diagnostic and/or therapeutic services.

The request for a consultation from the attending physician or other appropriate source and the need for consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated to the requesting physician or other appropriate source.

A consultation initiated by a patient and/or family, and not requested by a physician, is not reported using the initial consultation codes but may be reported using the codes for confirmatory consultation or office visits, as appropriate.

Any procedure that can be identified with a specific CPT code performed on or subsequent to the date of the initial consultation should be reported separately.
If a consultant subsequently assumes responsibility for management of a portion or all of the patient's condition(s), the consultation codes should not be used.

Department of Industrial Accidents (DIA). A department of the Commonwealth of Massachusetts Department of Labor and Workforce Development that oversees the Workers' Compensation system pursuant to M.G.L. c. 152 and other applicable laws and waivers.

Department of Public Health (DPH). A department of the Commonwealth of Massachusetts as established under M.G.L.c.17, § 1 that oversees and licenses healthcare facility standards and operations in addition to administering public health programs for all Massachusetts residents.

Description. A description of the medical procedure or item assigned to the Code based upon Current Procedural Terminology (CPT) or Health Care Common Procedure Coding System (HCPCS) which may include certain stipulations relevant to Massachusetts under M.G.L.c.152.

Division. The Division of Health Care Finance and Policy (DHCFP) Policy is a Division of the Commonwealth of Massachusetts Executive Office of Health and Human Services established under M.G.L.c.118G, formerly the Rate Setting Commission.

Eligible Provider. A provider as defined under 114.3 CMR 40.05, who also meets such conditions of participation as have been or may be adopted from time to time by a governmental unit or purchaser under M.G.L. c. 152. Out-of-state providers shall meet the comparable conditions of licensure and participation required by the state in which they practice.

Established Patient. A patient who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years. Under 114.3 CMR 40.00 the definition shall be applied to a single work related injury or episode of illness.

Fee. The payment value for the medical procedure or item contained in 114.3 CMR 40.06 and identified by a Code. Fees may be listed as Professional Component Fee ("PC Fee"), Technical Component Fee ("TC Fee") and Global Fee ("GL Fee") when a professional, technical or global fee applies. Single payment rates are listed as "Fees". See definitions of (GL), (PC) and (TC) below.

Global Fee (GL). The Global Fee is the sum of the PC Fee and TC Fee. See definitions of (PC) and (TC) below.

Governmental Unit. A governmental unit is defined as any division, department, agency, board or commission of the Commonwealth and any political subdivision of the Commonwealth or the Commonwealth in its entirety.

Levels of Evaluation/Management (E/M) Services. The Evaluation/Management section (CPT codes 99201-99499) is divided into broad categories such as office visits, hospital visits and consultations. Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are not interchangeable among the different categories or subcategories of service.

The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision and similar medical services. The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of E/M services may be used by all physicians and nurses as specified in 114.3 CMR 40.05(10) and 114.3 CMR 40.05(15). In addition, an array of E/M services codes and fees are included for certain eligible providers as listed in sections within 114.3 CMR 40.06.

Coordination of care with other providers or agencies without a patient encounter on that day is reported using the case management CPT codes (99361-99373). For a full discussion of the levels of E/M services, refer to the CPT "Guidelines" issued annually by the CPT Editorial Panel of the American Medical Association (AMA).

Modifiers. There are CPT and HCPCS modifiers for each level of codes maintained and updated on an annual basis by the AMA. Two digit numeric or character modifiers should be used to identify circumstances that alter or enhance the description of a service or supply. 114.3 CMR 40.07(1) Appendix A lists a limited number of the common modifiers and certain reimbursement provisions associated with their use. However providers, suppliers and carriers may utilize any current CPT Level I and HCPCS Level II National Modifiers as necessary. A full list of modifiers is contained in CPT "Guidelines" issued annually by the CPT Editorial Panel of the American Medical Association (AMA).

Professional Component (PC). Certain procedures are a combination of a physician, or professional component and a technical component. When the modifier –26 is added to an appropriate code a PC allowable amount shall be paid.

Special Report. A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. These services are generally reported as "unlisted services or procedures" and designated by digits '99' after the first three beginning code numbers. Pertinent information should include, but not be limited to, an adequate definition or description of the nature, extent, and need for the procedure; and the time, effort and equipment necessary to provide the service. Additional items which can be included are: complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

Technical Component (TC). The TC component reflects the technical portion of the radiology, laboratory, medical, or surgical procedure code. When the technical component is provided by a health care provider other than the physician providing the professional component, the health care provider bills for the technical component by adding Modifier –TC to the applicable code. The TC rate is payment for the facility's cost of rent, equipment, utilities, supplies, administrative and technical salaries and benefits, and all other overhead expenses.

Unlisted Procedure or Service. A service or procedure may be provided that is not listed in Regulation 114.3 CMR 40.06. When reporting such a service, the appropriate "Unlisted Procedure" code may be used to indicate the service. A "Special Report" may be required when billing codes for unlisted procedures.

(2) Copyright Notice. For more detail on CPT refer to the Physicians' *Current Procedural Terminology*, copyright 2003 American Medical Association, and any later updates. These CPT publications contain the complete and most current listings of CPT descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures.

(3) Other Service Providers Not Covered by this Regulation. Worker's Compensation Utilization Review as required by 452 CMR 6.00 authorizes healthcare treatment measures from time to time performed by practitioners of alternative or complementary care, such as massage therapists, who are not governed by 114.3 CMR 40.00. In such a case, the insurer, the employer and the health care service provider must agree upon the appropriate method of billing for treatment, e.g. the code, and the payment rate for such services.

(4) Services and Rates Covered by other Regulations.

(a) Other Services.

1. It is the policy of the Division of Health Care Finance and Policy to utilize the rules and reimbursement rates for governmental purchasers for certain healthcare services. These services and the regulations governing their rates of payment are the following:

Regulation Title	**Regulation Number**
Abortion and Sterilization	114.3 CMR 13.00
Adult Day Health Services	114.3 CMR 10.00
Ambulance Services	114.3 CMR 27.00
Chronic Maintenance Dialysis Treatment and Home Dialysis Supplies	114.3 CMR 37.00
Hearing Aid Dispensers	114.3 CMR 23.00
Home Health Services (includes private duty nursing referred to as continuous skilled nursing care)	114.3 CMR 50.00
Hospice Services	114.3 CMR 43.00
Independent Living Services for the Personal Care Attendant Program	114.3 CMR 9.00
Outpatient Tuberculosis Control Services	114.3 CMR 8.00
Prescribed Drugs	114.3 CMR 31.00
Psychiatric Day Treatment Center Services	114.3 CMR 7.00
Rates for Community Health Centers	114.3 CMR 4.00
Rates of Payment for Mental Health Services Provided in Community Health Centers and Mental Health Centers	114.3 CMR 6.00
Rest Homes	114.2 CMR 4.00
Skilled Nursing Facilities and Transitional Care Units	114.2 CMR 6.00
Substance Abuse	114.3 CMR 46.00
Vision Care and Ophthalmic Materials	114.3 CMR 15.00

2. Rate List Updates. Updates to rates affected by amendments to regulations cited in 114.3 CMR 40.02(4)(a)(1) will be posted on the Division web site. However, rates for Rest Homes pursuant to 114.3 CMR 4.00 and Skilled Nursing Facilities and Transitional Care Units pursuant to 114.3 CMR 6.00 must be obtained by calling DHCFP Provider Assistance.

(b) Hospitals. Workers' Compensation reimbursement within DPH licensed Massachusetts hospitals and out-of-state hospitals, when applicable, is governed by DHCFP regulation 114.1 CMR 41.00, Rates of Payment for Services Provided to Industrial Accident Patients by Hospitals. However, under chapter 398 of the Acts of 1991, the Division is required to establish rates for comparable services "regardless of the setting" in which they are provided. Therefore, 114.1 CMR 41.00 contains many references to regulation 114.3 CMR 40.00 for most services delivered in hospital outpatient settings. When such hospital services or procedures are unlisted and/or priced at individual consideration (I.C.) under 114.3 CMR 40.00, the hospital specific payment on account factor (PAF), or, if one is unavailable, the out-of-state PAF applied to charges will be used to determine the facility reimbursement rate.

40.03: Notification Process.

(1). Notices of Revision.

(a) Notification of planned updates to 114.3 CMR 40.00 is published in a Notice of Public Hearing after changes are officially proposed at the Division. Interested parties are given an opportunity to express their comments during the public hearing both in person and/or in writing at any time during the public comment period. The Notice of Public Hearing is published in two daily newspapers and in the Massachusetts Register at least twenty-one days prior to a public hearing. Copies of Notice(s) of Public Hearing are available in each county court law library in the Commonwealth. Information regarding revisions to 114.3 CMR 40.00 relevant regulations and workers' compensation rates is available through the Division's electronic subscription service. Notice(s) of Public Hearing are mailed to Division Document Service subscribers and posted on the Division web site.

(b) Promulgated copies of 114.3 CMR 40.00 can be obtained by contacting DHCFP, Office of Public Information, or at the State House bookstore. Final amendments will be posted on the Division's web site after adoption.

40.04 Provisions Affecting All Providers

(1) Eligible Providers. In addition to meeting licensure and other requirements applicable to the provider industry as specified under 114.3 CMR 40.05, an eligible provider must also meet such conditions of participation as may be required by a governmental unit or by a purchaser under M.G.L. c. 152.

(2) Rate Determination. The rates of payment set forth in 114.3 CMR 40.06 shall constitute full payment for services provided under M.G.L. c. 152 §13, as well as any related administrative or overhead costs. However, the insurer, the employer and the health care service provider may agree upon an alternative rate of payment for any service contained in this fee schedule. In no event shall an employee be liable for the compensation of health care services under M.G.L. c. 152 §13.

(3) Out-of-State Providers. Rates of payment for out-of-state providers are determined in accordance with 114.3 CMR 40.04(2), except where otherwise specifically noted herein.

(4) Individual Consideration (I.C.). Services that are authorized but are unlisted or designated "I.C." are individually considered items. The purchaser under M.G.L. c. 152 shall analyze the eligible provider's report of services rendered and charges submitted under the appropriate service or procedure category. Unless otherwise stated in sections under 114.3 CMR 40.05, Policies for Individual Service Types, determination of appropriate payment for procedures designated I.C. shall be in accordance with the following standards and criteria:
   (a) The amount of time required to perform the procedure,
   (b) The degree of skill required in care rendered,
   (c) The severity or complexity of the patient's disease, disorder or disability,
   (e) The policies, procedures and practices of other third party insurers,
   (f) A copy of the current invoice from the supplier.

(5) Special Codes and Modifiers for Industrial Accident Treatment Providers. Certain direct care providers may utilize Modifier -32 Mandated Services to enhance payment rates as listed within provider sections 114.3 CMR40.05. Use of this modifier will indicate the additional work required under 452 CMR 1.13(1) performed for comprehensive initial visits and visits that determine changes in work capability. Codes 99371-99373 are also provided within 114.3 CMR 40.06 for required telephone consult as reimbursable expense for consultation between providers and employers, insurers, utilization reviewers or agents.

(6) Utilization Standard. Treatment guidelines pertaining to work place injury and illness are published and updated periodically by the Department of Industrial Accidents, Healthcare Services Board. These guidelines are used to define appropriate care deemed medically necessary.

40.05: Policies for Individual Service Types

(1) Acupuncture
   (a) Eligible Providers. Any person licensed by the Board of Registration in Acupuncture under M.G.L. c. 112, §§ 148 to162, inclusive, to practice acupuncture.
   (b) Definition. Acupuncture is the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, with or without the application of electric current, and with or without the application of heat to the needles, skin or both, in an attempt to relieve pain or improve bodily function. Acupuncture is based upon traditional oriental medical theories. Services include examinations, Evaluation and Management services (E/M), acupuncture treatments and supportive services. The acupuncture treatment codes include a patient assessment. Additional E/M services may be reported separately using the modifier '-25', if the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with the procedure.
   (c) Fees. Rates of payment for acupuncture services are contained in 114.3 CMR 40.06 (1).
   (d) Modifier -32 - Mandated Services. Services related to mandated consultation and/or related service (eg. PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier '32' to the basic procedure. [Use modifier -32 in addition to an Evaluation and Management (E/M) code to identify an initial/comprehensive office visit for the purpose of an injury assessment and in-depth evaluation of medical complaint(s) and present injury, past medical history, system review, physical examination, ordering of appropriate tests and procedures, and the preparation of an appropriate report as required under 452 CMR 1.13(1). If a confirmatory consultation is required, eg, by a third party payor, the modifier '-32', mandated

services, should also be reported. The addition of modifier -32 to the E/M code allows 115% of the allowable fee listed to be paid to the eligible provider.]

(e) Modalities and Supportive Procedures. A charge may be assessed for modalities only in conjunction with an acupuncture treatment performed during the course of the same visit.

(f) Nutritional Supplements. The rate of payment for nutritional supplements shall be equal to the at invoice cost, plus the dispensing fee of $3.00.

(2) Anesthesia Services

(a) Eligible Providers.

1. A licensed medical doctor or licensed osteopath, other than an intern or resident, who is authorized by the Board of Registration in Medicine in accordance with the provisions of M.G.L.c.112.
2. A certified registered nurse anesthetist (CRNA) who is licensed and subject to the rules and requirements in accordance with the provisions of M.G.L.c.112 and 244 CMR 4.00 to practice as a CRNA. The CRNA is limited to those procedures within the scope of CRNA services and subject to the rules of physician relationship for reimbursement defined by the Commonwealth's Nurse Practice Act. The CRNA is a full-time employee of the eligible physician provider and not salaried by the hospital. Availability by telephone shall not constitute direct supervision; however, the physician need not be in the room where the services are being performed.

(b) Anesthesia Services. Services involving administration of anesthesia are reported by the use of the anesthesia five-digit CPT code (00100 to 01999) plus modifier codes. Services include but are not limited to general, regional, supplementation to local anesthesia, or other supportive services for optimal anesthesia care to the patient. These services include the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services, (e.g. ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). However, these services do not include preoperative and postoperative services or pain management services, which may be separately billable. Unusual forms of monitoring beyond the basic anesthesia service (e.g. intra-arterial, central venous, and Swan-Ganz) are not included and will be reimbursed separately based on the appropriate medical or surgical fee schedule.

(c) Fees. Rate of payment for anesthesia services is contained in 114.3 CMR 40.05(2)(g) for use with base units contained in 114.3 CMR 40.06 (2). Fees for supplies and materials provided by the physician (e.g. sterile trays, drugs) over and above those usually included with the office visit or other services rendered may be listed separately using code 99070.

(d) Modifier -32 - Mandated Services. Services related to mandated consultation and/or related service (eg. PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier '32' to the basic procedure. [Use modifier -32 in addition to an Evaluation and Management (E/M) code to identify an initial/comprehensive office visit for the purpose of an injury assessment and in-depth evaluation of medical complaint(s) and present injury, past medical history, system review, physical examination, ordering of appropriate tests and procedures, and the preparation of an appropriate report as required under 452 CMR 1.13(1). If a confirmatory consultation is required, eg, by a third party payor, the modifier '-32', mandated services, should also be reported. The addition of modifier -32 to the E/M code allows 115% of the allowable fee listed to be paid to the eligible provider.]

(e) Payments for Qualified CRNAs. Utilize the appropriate 2 digit modifier listed in 114.3 CMR 40.07 Appendix A to denote services rendered by a non-physician provider. Payments to employer's billing for eligible CRNAs as specified in 114.3 CMR 40.05(2)(a)2 are:

1. 50% of the fees specified in 114.3 CMR 40.05(2)c. for CRNA services with medical direction of 2, 3 or 4 concurrent procedures by a physician, or
2. 100% of the allowable fee specified in 114.3 CMR 40.05(2)c. for CRNA services with medical direction of one CRNA or without direction by a physician.

(f) Time Reporting. Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room (or its equivalent area) and ends when the anesthesiologist is no longer in personal attendance, i.e. when the patient is placed in postoperative supervision.

(g) Qualifying Circumstances. Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions, and/or unusual risk factors. List CPT codes 99100 to 99140 as additional procedure numbers qualifying an anesthesia procedure or service.

Qualifying	Description	Unit Value

Circumstances in CPT		
99100	Anesthesia for a patient of extreme age, under one year and over seventy	1
99116	Anesthesia complicated by utilization of total body hypothermia	5
99135	Anesthesia complicated by utilization of controlled hypotension	5
99140	Anesthesia complicated by emergency conditions (an emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.)	2

(h) Determining Payment for Anesthesia Services. Anesthesia codes must be used and the time reported in minutes on the claim form to ensure proper payment. Reimbursement will be determined by the addition of base units, time units and modifying units (if any) and multiplying this sum by a rate per unit. Each time unit equals 15 minutes.

PAYMENT *EQUALS* :	(TIME UNITS + BASE UNITS + MODIFYING UNITS)
	TIMES $19.86 (Rate per UNIT)

(i) Special Coding Situations.

1. Multiple Procedures. When multiple surgical procedures are performed during a single anesthetic administration, report only the anesthesia procedure with the highest unit value. The time reported should be the combined total for all procedures performed.
2. Anesthesia Modifiers. Physical status and common CPT modifiers used in conjunction with anesthesia codes can be found in 114.3 CMR 40.07(1) Appendix A.
3. Postoperative Pain Management. Postoperative pain management are payable as additional procedures and are reported as follows:

   Epidural or subarachnoid pain management is reported with procedure codes 62310-62319 for placement of the epidural or subarachnoid catheter that includes the initial day of pain management.

   Subsequent management is reported with 01996 and is reported per day.

   Patient-controlled anesthesia is reported with 01997 on a per day basis.

(3) Chiropractic Services

(a) Eligible Providers. An individual licensed by the Board of Registration of Chiropractors in accordance with the provisions of M.G.L.c.112.

(b) Chiropractic Services. Services include examinations, Evaluation and Management services (E/M), Chiropractic Manipulative Treatment (CMT), therapeutic (supportive) procedures and modalities. The chiropractic manipulative treatment codes include a pre-manipulation patient assessment. Additional E/M services may be reported separately using the modifier '-25', if the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with the procedure.

For purposes of CMT, the five spinal regions referred to are: cervical region (includes atlanto-occipital joint); thoracic region (includes costovertebral and costotransverse joints); lumbar region; sacral region; and pelvic (includes sacro-iliac joint) region. The five extraspinal regions referred to are: head (including

temporomandibular joint, excluding atlanto-occipital) region; lower extremities; upper extremities, rib cage (excluding costotransverse and costovertebral joints) and abdomen.

When an extraspinal manipulation (code 98943) is performed in conjunction with CMT codes 98940 through 98942, the Multiple Procedure modifier -51 must be added to code 98943 indicating payment at 50% of the allowable fee contained in 114.3 CMR 40.06.

(c) Fees. Rates of payment for chiropractic services are contained in 114.3 CMR 40.06 (3).
(d) Modifier -32 - Mandated Services. Services related to mandated consultation and/or related service (eg. PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier '32' to the basic procedure. [Use modifier -32 in addition to an Evaluation and Management (E/M) code to identify an initial/comprehensive office visit for the purpose of an injury assessment and in-depth evaluation of medical complaint(s) and present injury, past medical history, system review, physical examination, ordering of appropriate tests and procedures, and the preparation of an appropriate report as required under 452 CMR 1.13(1). If a confirmatory consultation is required, eg, by a third party payor, the modifier '-32', mandated services, should also be reported. The addition of modifier -32 to the E/M code allows 115% of the allowable fee listed to be paid to the eligible provider.]
(e) Modalities and Supportive Procedures. A charge may be assessed for modalities (97010-97039) only in conjunction with a chiropractic treatment performed during the course of the same visit. Service provisions pertaining to physical medicine are contained in 114.3 CMR 40.05(13) and rates of payment for supportive procedures are listed in 114.3 CMR 40.06(12).
(f) Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) . Rates of payment for durable medical equipment, prosthetic/ orthotics and supplies are listed in 114.3 CMR 40.06(6) and subject to the provisions and guidelines contained in 114.3 CMR 40.05 (6).
(g) Nutritional Supplements. The rate of payment for nutritional supplements shall be equal to the invoice cost, plus the dispensing fee of $3.00.
(h) Radiology. Rates of payment for radiological services are listed in 114.3 CMR 40.06(7) subject to the provisions and guidelines contained in 114.3 CMR 40.05(12)

(4) Clinical Laboratory Services
(a) Eligible Providers. An independent licensed clinical diagnostic laboratory, a diagnostic laboratory in a physician's office or a hospital laboratory maintained for its outpatient services. Payment for clinical laboratory tests subject to 114.3 CMR 40.06(4) shall apply to the person or entity performing or supervising the performance of the tests.
(b) Clinical Laboratory Services. Microbiological, chemical, hematological, biophysical, cytological, immunohematological, or pathological examinations performed in a laboratory on materials derived from the human body to provide information for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition.
(c) Fees. Rates of payment for clinical laboratory services are contained in 114.3 CMR 40.06 (4). Rates for physician laboratory services, i.e. anatomic and surgical pathology (CPT codes 88000-88099 and 88300-88399) are contained under Surgery in 114.3 CMR 40.06 (8).
(d) When the physician's administration of the supplies and drugs includes items over and above the usual service rendered (e.g. sterile trays, drugs, supplies and materials), list separately using code 99070. To report physician attendance and monitoring during the testing, use the appropriate evaluation and management code, including the prolonged physician care codes if required. Prolonged physician care codes are not separately reported when evocative/suppression testing involves prolonged descriptors where reference is made to a particular analyte (e.g., Cortisol (82533 X 2)) the "x 2" refers to the number of times the test for that particular analyte is performed.
(e) Consultations (Clinical Pathology). A clinical pathology consultation (CPT codes 80500-80502) is a service, including a written report, rendered by the pathologist in response to a request from an attending physician in relation to a test result(s) requiring additional medical interpretive judgment.
(f) Chemistry. When an analyte is measured in multiple specimens from different sources, or in specimens that are obtained at different times, the analyte is reported separately for each source and for each specimen. The examination is quantitative, unless otherwise specified. When a code describes a method where measurement of multiple analytes may require one or several procedures, each procedure is coded separately (e.g., 82491-82492, 82541-82544). Clinical information derived from the results of laboratory data that is mathematically calculated (e.g., free thyroxine index (T7)) is considered part of the test procedure and is not a separately reportable service.

(g) Immunology. CPT codes 86000-86849 are qualitative or semiquantitative immunoassays performed by multiple step methods for the detection of antibodies to infectious agents. For immunoassays by single step method use code 86318. Procedures for the identification of antibodies should be coded as precisely as possible. For example, an antibody to a virus could be coded with increasing specificity for virus, family, genus, species, or type. In some cases, further precision may be added to codes by specifying the class of immunoglobulin being detected. When multiple tests are done to detect antibodies to organisms classified more precisely than the specificity allowed by available codes, it is appropriate to code each as a separate service.

(h) Microbiology. CPT codes 87001-87999 include bacteriology, mycology, parasitology, and virology. Presumptive identification of microorganisms is defined as identification by colony morphology, growth on selective media, Gram stains, or up to three tests (e.g., catalase, oxidase, indole, urease). Definitive identification of microorganisms is defined as identification to the genus or species level that requires additional tests (e.g., biochemical panels, slide cultures). If additional studies involve molecular probes, chromatography, or immunologic techniques, these should be separately coded in addition to definitive identification codes (CPT codes 87140-87158). For multiple specimens/sites use modifier '–59'. For repeat laboratory tests performed on the same day, use modifier '-91'.

(i) Pricing of Automated Tests. The total number of actual tests will determine the fee payable for automated tests whether billed individually or as part of a panel test. For example, if the total of 3 automated tests are performed on one blood draw from a patient the total allowed for these tests will be $9.29, the pricing equivalent for 3 tests.

(5) Dental Services

(a) Eligible Providers.

1. A dentist registered by the Board of Registration in Dentistry in accordance with the provisions of M.G.L. c.112; or
2. Authorized governmental, nonprofit or charitably incorporated dental clinics not involved with teaching dental students; or
3. Authorized dental clinics that wholly or partially derive support from Title V Funds under the Social Security Act; or
4. Teaching dental clinics operated by dental education institutions.

(b) Dental Services. Dental services include, but are not limited to, diagnostic, consultative and evaluative oral examinations, X-rays, preventive, restorative, endodontic, periodontic, prosthodontic, surgical, exodontic and orthodontic procedures and appliances.

(c) Fees. Rates of payment for dental services are contained in 114.3 CMR 40.06 (5).

(d) Modifier -32 - Mandated Services. Services related to mandated consultation and/or related service (eg. PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier '32' to the basic procedure. [Use modifier -32 in addition to a clinical oral evaluation or emergency treatment code to identify an initial/comprehensive office visit for the purpose of an injury assessment and in-depth evaluation of dental complaint(s) and present injury, past medical history, system review, physical examination, ordering of appropriate tests and procedures, and the preparation of an appropriate report as required under 452 CMR 1.13(1). If a confirmatory consultation is required, eg, by a third party payor, the modifier '-32', mandated services, should also be reported. The addition of modifier -32 to the code allows 115% of the allowable fee listed to be paid to the eligible provider.]

(e) Surgery. Rates of payment for surgical dental services are listed in 114.3 CMR 40.06(8) and subject to the provisions and guidelines contained in 114.3 CMR 40.05 (14).

(f) Codes and Descriptions. All codes and descriptions are copyrighted by the American Dental Association's Current Dental Terminology, (CDT-4).

(6) Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS).

(a) Eligible Providers and Exclusions.

1. Eligible Providers.

a. Any person, partnership, corporation, or other entity which is authorized by the Commonwealth of Massachusetts to engage in the business of furnishing:
Durable Medical Equipment (DME),
Medical and surgical supplies,
Customized equipment,
Oxygen or respiratory therapy equipment,

Mobility systems,
Intravenous and enteral therapy equipment,
And related supplies and services.

b. Certain providers may be authorized under 114.3 CMR 40.05 to provide equipment or supplies relative to their specialty in an office setting.
c. An eligible prostheses provider certified by the American Board for Certification in Prosthetics and Orthotics (P&O) with experience and knowledge of upper and lower extremity prostheses, cosmetic restoration and devices for traumatic or congenital deformities, their design, fabrication and fitting.
d. Any person, partnership, corporation or other entity that is authorized by the Commonwealth of Massachusetts to engage in the business of furnishing orthotic devices. In addition, at the discretion of the purchasing agency, a provider of certain orthotic devices must be a certified orthotist who has experience in and knowledge of upper and lower extremity bracing, torso, and spinal bracing, devices for congenital deformities, their design, fabrication and fitting.

2. Exclusions. 114.3 CMR 40.00 and the rates of payment contained herein shall not apply to the following services:
   a. Respiratory therapy services rendered by a qualified respiratory therapist;
   b. Any oxygen provided to a nursing home which is reimbursed under the per diem rate for such nursing home;
   c. All services for inpatients at a facility licensed as an acute or chronic hospital.

(b) General Provisions

1. Coverage. 114.3 CMR 40.00 and the rates of payment contained herein shall apply to the following situations:
   a. the purchase or rental of durable medical equipment;
   b. the purchase or rental of medical/surgical supplies;
   c. the purchase or rental of prescribed oxygen delivery systems and respiratory therapy equipment and related supplies;
   d. the purchase or rental of seating, positioning, mobility systems and related accessories;
   e. the purchase or rental of intravenous and enteral supplies, equipment and services; and
   f. the repair of the above listed types of equipment.
2. Pre-authorization for equipment and/or services. Insurers and other payers under 114.3 CMR 40.00 may require pre-authorization, recertification and/or other requirements documenting medical necessity for equipment and related supplies and services under this section. In most cases, the physician's prescription for the equipment and other medical information available will be sufficient to establish that the equipment is necessary and suitable in the treatment of the illness or injury. Providers should determine if there are documentation and coverage requirements associated with a prescription for durable medical supplies.
3. Services in this section are organized according to HCPCS as follows:

Section	**HCPCS CODE RANGE**
Medical and Surgical Supplies	A4214-A8999
Miscellaneous and Administrative	A9900-A9999
Enteral and Parenteral Therapy	B4000-B9999
Ambulation Devices	E0100-E0159
Commodes and Accessories	E0160-E0175
Decubitus Care Equipment	E0176-E0199
Heat/Cold Application	E0200-E0239
Bath and Toilet Aids	E0241-E0249
Hospital Beds and Accessories	E0250-E0373,
Oxygen and Related Respiratory Equipment	E0424-E0606, E1353-E1406
Monitoring Equipment	E0607-E0620
Patient Lifts	E0621-E0638
Pneumatic Compressor and Appliances	E0650-E0675
Ultraviolet Cabinet	E0691-E0694
Safety Equipment and Restraints	E0700-E0701, E0710
Transcutaneous and/or Neuromuscular Electrical Nerve	E0720-E0765

Section	HCPCS CODE RANGE
Stimulators (TENS)	
Infusion Supplies	E0776-E0791
Traction Equipment, Trapeze Equipment, Fracture Frame and Other Orthopedic Devices	E0830-E0948
Wheelchairs, Mobil Arm Supports	E0950-E1298, E2201-E2399
Whirlpool Equipment	E0300-E1310
Repairs	E1340
Artificial Kidney Machines and Accessories	E1500-E1699
Jaw Motion Rehabilitation System and Accessories	E1700-E1702
Other Orthopedic Devices, Miscellaneous	E1800-E1840, E1902-E2120, E2500-E2599

(c) Fees. Rates of payment for DMEPOS, are contained in 114.3 CMR 40.06(6).

(d) Payment Methodology. DME fee schedules are calculated for the following DME payment classes:

Inexpensive and Other Routinely Purchased Items (IN): These items have a purchase price of $150 or less, or are generally purchased 75% of the time or more, or are accessories used in conjunction with certain nebulizers, aspirators, and ventilators. These items can be purchased new or used and can be rented; however, total payments cannot exceed the purchase new fee for the item.

Frequently Serviced Items (FS). These items require frequent and substantial servicing. These items can be rented as long as they are medically necessary.

Oxygen and Oxygen Equipment. Payment for oxygen and oxygen equipment is made on a monthly basis. One bundled monthly payment amount is made for all covered stationary equipment, stationary and portable contents, and all accessories used in conjunction with the oxygen equipment. A monthly payment is made for oxygen contents only. An additional monthly payment may be made for portable oxygen.

Other Covered Items. Supplies that are necessary for the effective use of the DME.

Capped Rental Iems (CR). These items do not fall under any other DME payment category. They are generally expensive items which are routinely rented. Items designated as "capped rental" in the code description are rented for a maximum period of 15 months up to the purchase price, at which point the provider stops billing. The provider may bill for repairs as needed to maintain proper working condition of the equipment for the patient's use after the 15th month. The methodology for payment of items on a capped rental basis is as follows:

a. for the first 3 months of rental, 10% of the new purchase fee;
b. for months 4-15, 75% of the monthly fee for months 1-3.

When provided equipment is used for less than 1 month, the payment shall be prorated. To determine the daily rate, divide the monthly rental fee by the number of days in the applicable month. Multiply the daily rate times the number of rental days. For purchase of capped rental items, the purchase price will be no more than the sum of the capped rental methodology applied for 10 months.

Unlisted Items. Certain items that are not listed but may be prescribed as medically necessary for the treatment of illness or injury or to improve the functioning of a patient are payable under reimbursement policies for individually considered (I.C.) items in accordance with 114.3 CMR 40.05(6). When a code is not listed in 114.3 CMR 40.06(6), the item should be assigned an unlisted service or procedure code such as A9900 (Miscellaneous DME supply, accessory, and/or service component of another HCPCS code) or E1399 (Durable Medical Equipment, miscellaneous.) Customized items that are deemed medically necessary are payable at individual consideration (I.C.)

(e) General Definitions.

Adjusted Acquisition Cost. The price paid to a supplier by an eligible provider for durable medical equipment, medical/surgical supplies, customized equipment, oxygen and respiratory therapy equipment. The adjusted acquisition cost shall not exceed the manufacturer's current catalogue price.

At Invoice Cost (AI). The price paid by the provider net of any manufacturer discounts received. Documentation of AI cost must be supplied to purchaser for payment upon request.

Durable Medical Equipment (DME). Those products that:

a. are produced primarily and routinely to fulfill a medical purpose;
b. are generally not used in the absence of illness and injury;
c. can withstand repeated use over an extended period of time; and
d. are appropriate for home use.

Liquid Oxygen Systems. Oxygen and oxygen equipment as DME involves the system for furnishing it, the vessels that store it, the tubing, and administration sets that allow the safe delivery of oxygen in the home, and the oxygen contents.

Medical and Surgical Supplies. Medical and treatment products that:

a. are produced primarily and routinely to fulfill a medical or surgical purpose;
b. are used in the treatment of a specific medical condition;
c. are non-reusable and disposable.

Non-Standard Prescription Options. New mobility systems which include devices that:

a. provide their user with a substantially greater range of motion than are usually required of that particular device; or
b. require substantially greater service or time than are usually provided for that particular device.

Orthotic Device. A mechanical device that is designed to support or correct any defect of form or function of the human body, and generally known as a "brace" or "orthosis" but not including dental braces or breast prostheses.

Oxygen Delivery Systems. A comprehensive oxygen service that includes, but is not limited to: the gaseous /liquid oxygen, oxygen generating device and related delivery systems container or cylinder, manifold systems whenever high volume oxygen is used, stand, cart, walker/stroller, supply reservoir, contents indicator, regulator with flow gage, humidifcation devices, cannulas, masks, and special oxygen administration device, tubing and refill adapter.

Prostheses. A mechanical device that either replaces all or part of an extremity, generally known as an "artificial limb."

Prosthetic Device. Any substitute or ancillary equipment or component part used in a prosthesis for replacement or modification purposes.

Rehabilitation Techonology Specialist (RTS). A professional with expertise in assistive and rehabilitation technology, including wheeled mobility, seating and alternative positioning, ambulating assistance, environmental control and related activities who meets such conditions of participation (e.g., National Registry of Rehabilitation Technology Suppliers membership or Assistive Technology Supplier, Certified Rehabilitation Technology Supplier, Assistive Technology Pracitioner, or Rehabilitation Engineering Technology designation) as may be adopted by a governmental unit to work directly with consumers in the provision of wheeled mobility systems in the service delivery process.

Respiratory Therapy Devices and Supplies. Devices and necessary ancillary equipment prescribed by a physician for the care and treatment of pulmonary illnesses which meet such standards as may be required by federal or state governmental units. Respiratory Therapy Devices may include the complete device and related delivery system accessories such as, regulator with flow gage, humidification and heating units, filters, cannulas, masks, and special administration device tubing and adapters.

Seating, Positioning, Mobility Systems and Related Accessories. Any device including its components, accessories and/or modifications which has been prescribed, designed and constructed to meet the individualized custom needs of a patient, occupational and/or physical therapist(s), or orthotist, physician [and] DME provider representative. This equipment will be provided by an eligible DME provider who employs a Rehabilitation Technology Specialist (RTS). The equipment must fulfill a medical purpose and is generally not useful in the absence of illness, injury, can withstand repeated use over an extended period of time, is appropriate for home use, and meets professionally-recognized standards of quality.

Transcutaneous Electrical Nerve Stimulator (TENS). TENS devices are electrodes placed on the surface of the skin which utilize electrical current to decrease the patient's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins. A TENS unit

must be distinguished from other electrical stimulators that directly stimulate muscles and/or motor nerves, e.g., neuromuscular stimulators.

Used Equipment. Any item that has been previously purchased or rented, including equipment that was:

a. used by a patient for a trial period;
b. used by the supplier as a demonstrator; or
c. rented by a patient who now wants to buy it.

Usual and Customary Charge. The lowest fee charged to the general public by a DME or Oxygen and Respiratory Therapy Equipment, Medical Supply, Intravenous and Enteral Therapy, Seating, Positioning, and Mobility Systems provider specified by this section, which fee is in effect at the time that such service is performed or equipment is sold or rented.

(f) Individual Consideration (I.C.) Payment rate for individual consideration will be the lower of:

1. The eligible provider's usual and customary charge to the general public; or
2. The adjusted acquisition cost to the eligible provider plus a markup not to exceed:
   a. 30% for inexpensive and routinely purchased items;
   b. 40% for frequently serviced items, customized equipment, prosthetics and orthotics.

(g) .Labor Rate for Repair Services.

1. Payments for labor costs for repair code E1340 to an eligible provider for items that require additional service, intensive time or procedures, or that require repair, may be billed at the rate of $20.00 per 15 minutes.
2. Payments for labor costs for orthotic repair code L4205 and prosthetic repair code L7520 to an eligible provider for items that require additional service, intensive time or procedures, or that require repair, may be billed at the rate of $20.00 per 15 minutes.

(7) Freestanding Diagnostic Facilities

(a) Eligible Provider. A licensed freestanding diagnostic imaging facility or hospital.

(b) Freestanding Diagnostic Facility Services. Imaging services and radiology services include diagnostic radiology, diagnostic ultrasound and nuclear medicine.

(c) Fees. Rates of payment for freestanding diagnostic facilities and imaging technical components are contained in 114.3 CMR 40.06 (7).

(d) Definitions.

Computerized Axial Tomography Scans (CAT). The procedure in which computer-generated tomograph images are obtained and assembled to provide a three-dimensional view of a tissue layer.

Magnetic Resonance Imaging (MRI). An MRI is the medical application of nuclear magnetic resonance. The MRI device provides images of the internal structure of the head or body that correspond to the distribution of hydrogen nuclei (protons) exhibiting nuclear magnetic resonance. The images depend upon nuclear magnetic resonance parameters (spin-lattice relaxation time, spin-spin relaxation time, proton density and flow rate), which when interpreted by a trained physician can yield useful information in the determination of a diagnosis.

(e) General Rate Guidelines

1. The TC payment for CAT and MRI procedures that specify "with contrast" include payment for contrast media.
2. The TC rate for nuclear medicine (CPT codes 78000 through 78999) does not include the radionuclide used in connection with the procedure. These substances are separately billed under codes A4641 and A4642 for diagnostic procedures and are paid on an I.C. basis depending on the substance used.

(8) Freestanding Ambulatory Surgical Centers

(a) Eligible Provider. A DPH licensed freestanding ambulatory surgical center (FASC) or hospital outpatient surgical center.

(b) Freestanding Ambulatory Surgical Center Services. Centers for Medicare and Medicaid Services (CMS) recognizes a limited number of surgical procedures that can be performed safely in an ambulatory setting without requiring hospital admission. 114.3 CMR 40.06(8) contains CMS assigned payment group numbers from CMS list of covered procedures to determine facility payment amounts.

(c) Fees. Rates of payment for Ambulatory Surgical Centers (FASCs) are based upon rates effective 4-for Locality 009 to 024 issued in 2004 by CMS. FASC rates are contained in 114.3 CMR 40.06 (8). To determine payment for global surgical facilities within Massachusetts, select the group number (01 through

09) assigned to the surgical procedure code in 114.3 CMR 40.06 (8) and apply the allowable fee based upon group number for the county within which the FASC or hospital OPD is located .

(d) Out-of-state Providers. Payment rates for out of state providers under the Commonwealth's jurisdictional payment rules are determined according to 114.3 CMR 40.05 (8)(c) utilizing national payment levels.

(e) Global surgical procedures facility coverage. Services and the normal range of care required before and after surgery that is contained in the fee includes:

1. the immediate preoperative care at the facility prior to surgery on the same day,
2. local anesthesia, such as infiltration, and digital block or topical anesthesia ,
3. routine medical supplies and materials,
4. the facility fee, including a hospital operating room, cardiac catherization suite, laser suite, and an endoscopy suite equipped and staffed for the sole purpose of performing surgical procedures,
5. normal, uncomplicated postoperative care, including the hospital recovery room and pain management at the facility following surgery on the same day.

(f) Services not included in the global facility rate. The following services required in conjunction with the surgical procedure that should be reimbursed at their respective CPT/HCPCS rates are:

1. professional fees,
2. diagnostic biopsies performed on the same day preceding major surgery,
3. laboratory fees,
4. radiological services,
5. EKG and respiratory care.
6. Implanted DME, implanted prosthetic devices, replacement parts (external or internal), accessories and supplies for the implanted DME. These items shall be paid at invoice (A.I.) cost net of any manufacturer discounts received by the provider.
7. Coverage does not include medically appropriate, overnight observation stays in hospitals that are reimbursed using the hospital specific payment on account factor.
8. Preoperative and postoperative visits that do not occur at the time of the surgical visit.

(g) Modifiers. See 114.3 CMR 40.07(1) Appendix A for a list of Level 1 CPT modifiers.

(9) Homemaker

(a) Eligible Provider. An individual, partnership or corporation that employs homemakers.

(b) Homemaker Services. Services that comply with the Homemaker Standards issued by the Executive Office of Elder Affairs to assist a client with Instrumental Activities of Daily Living which include the following:

1. shopping,
2. menu planning,
3. meal preparation (includes special diets),
4. laundry, and
5. light housekeeping.

(c) Fees. Rate of payment for homemaker services is contained in 114.3 CMR 40.06 (9).

(d) Definitions.

Executive Office of Elder Affairs. A Secretariat of the Commonwealth of Massachusetts that oversees services and administers activities through a network of local Councils on Aging and nutrition projects, regional Aging Services Access Points (ASAPs) and Area Agencies on Aging (AAAs).

Instrumental Activities of Daily Living (IADLs). Specific activities to physically assist with tasks incidental to the care of a patient such as meal preparation and clean-up, household services, laundry, shopping, housekeeping, transportation to a medical provider, or assistance with the care and maintenance of adaptive devices.

(10) Medicine

(a) Eligible Providers:

1. A licensed physician or licensed osteopath other than an intern, resident, or house officer who is authorized by the Board of Registration in Medicine in accordance with the provisions of M.G.L.c.112.
2. A licensed, registered podiatrist other than an intern, resident, or house officer who is authorized by the Board of Registration in Medicine in accordance with the provisions of M.G.L.c.112, whose eligibility is limited to those procedures within the scope of his/her licensure.

3. A licensed registered nurse who is authorized by the Board of Registration in Nursing in accordance with the provisions of M.G.L.c.112 to practice as a nurse practitioner (NP), limited to those procedures within the scope of NP services and subject to the rules of physician relationship for reimbursement defined by the Commonwealth's Nurse Practice Act. A licensed physician assistant (PA) who is authorized by the Board of Registration for Physician Assistants in accordance with the provisions of M.G.L.c.112, may not bill separately for services rendered.
4. A licensed, registered podiatrist other than an intern, resident, or house officer who is authorized by the Board of Registration in Podiatry in accordance with the provisions of M.G.L.c.112, whose eligibility is limited to those procedures specified by the purchaser of the services.

(b) Medicine Services. Services in this section are organized according to CPT as follows:

Section	CPT CODE RANGE
Evaluation and Management	99201-99499
Immunization, Vaccines and Infusions – (JCodes are listed in 114.3 CMR 40.07(4) Appendix D)	90281-90799, J codes
Psychiatry	90801-90899
Biofeedback	90901-90911
Dialysis	90918-90999
Gastroenterology	91000-91299
Ophthalmology, Contact Lens Services, Ocular Prosthetics, Spectacle Services and Supplies	92002-92499
Otorhinolaryngologic Services, Vestibular Function Tests, Audiologic Function Test, Evaluative and Therapeutic Services	92502-92700
Cardiovascular Services	92950-93799
Non-Invasive Vascular Diagnosis Studies	93875-93990
Pulmonary	94010-94799
Allergy and Clinical Immunology	95004-95199
Endocrinology	95250
Neurology and Neuromuscular Procedures	95805-95999
Motion Analysis, Central Nervous System Assessments/Tests	96000-96155
Chemotherapy Administration, Photodynamic Therapy	96400-96549, 96567-96571
Dermatology	96900-96999
Physical Medicine and Rehabilitation, Active Wound Care Mangement, Tests and Measurement, Acupuncture, Medical Nutrition Therapy	97001-97799, 97601-97602, 97703-97755, 97780-97781, 97802-97804
Osteopathic and Chiropractic Treatments	98925-98943
Special Services, Procedures and Reports	99000-99199
Evaluation and Management	99201-99499
Home Health Procedures / Services	99500-99539
Home Infusion Procedures	99551-99569

(c) Fees. Rates of payment for medicine services are contained in 114.3 CMR 40.06 (10).

(d) Modifier -32 - Mandated Services. Services related to mandated consultation and/or related service (eg. PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier '32' to the basic procedure. [Use modifier -32 in addition to an Evaluation and Management (E/M) code to identify an initial/comprehensive office visit for the purpose of an injury assessment and in-depth evaluation of medical complaint(s) and present injury, past medical history, system review, physical examination, ordering of appropriate tests and procedures, and the preparation of an appropriate report as required under 452 CMR 1.13(1). If a confirmatory consultation is required, eg, by a third party payor, the modifier '-32', mandated

services, should also be reported. The addition of modifier -32 to the E/M code allows 115% of the allowable fee listed to be paid to the eligible provider.]

(e) Payments for Qualified NPs and PAs. Payment to employers billing for eligible NPs and PAs as specified in 114.3 CMR 40.05(10)(a)3 is 85% of the fees contained in 114.3 CMR 40.06. Utilize the appropriate 2-digit modifier listed in 114.3 CMR 40.07 Appendix A to denote services rendered by a non-physician provider.

(f) Modifiers. See 114.3 CMR 40.07(1) Appendix A for a list of Level 1 CPT modifiers.

(g) Maximum Allowable Fees – Medical Services

1. Office Visits. The office visit fees listed herein apply only when the eligible provider customarily bills for services rendered, and do not apply in the case where a hospital submits an all-inclusive outpatient charge.
2. Drugs, Medications, Supplies and Laboratory Specimen Collections Supplies and materials used in preparation for or as part of a procedure (e.g., bandages, laboratory kits, syringes or disposable gloves) are not reimbursed separately, but included in the office visit rate. In addition, no supplemental charge shall be submitted nor payment allowed for routine specimen collection in a physician's office and preparation for clinical laboratory analysis (and activities related thereto), e.g., venipuncture, urine, fecal and sputum samples, culturing, swabbing and scraping for removal of tissues.
3. Payments for Other Services. Where applicable, payment for drugs, medicines, supplies, and related materials dispensed to patients shall be in accordance with rates which are the subject matter of other regulation sections that may be in effect and germane to the item in question (e.g., laboratory, pharmacy, medical supplies, etc.) not to exceed the cost of the item to the physician.

   In other instances where the use of another service type is not appropriate, certain supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered should be billed under code (99070).
4. Medication and Injections. Medication and injectables not available free of charge from the Department of Public Health may be billed under the appropriate J Code at invoice (A.I.) cost net of any manufacturer discounts received by the provider. See 114.3 CMR 40.07(4) Appendix D List for a list of J codes or if the code is not available, use an unlisted procedures category (such as code 90749 for immunizations or code 99070 under miscellaneous services).

   Immunization injections are usually given in conjunction with a medical service. When an immunization is the only service performed, a minimal service (such as codes 90471, 90472 or 96400) may be listed in addition to the injection and an office visit should not be separately billed. Immunization procedures include the supply of materials.

5. Physical Medicine. Service provisions pertaining to physical and restorative medicine are contained in 114.3 CMR 40.05(13) and codes and fees for physical medicine procedures are listed in 114.3 CMR 40.06(12).

(11) Psychology

(a) Eligible Provider.

1. A psychologist who is licensed by the Massachusetts Board of Registration of Psychologists in accordance with the provisions of M.G.L.c.112, or
2. A social worker (LICSW) who is licensed by the Massachusetts Board of Registration of Social Work in accordance with the provisions of M.G.L.c.112.
3. Psychiatric Services provided by a licensed physician are contained under Medicine in accordance with 114.3 CMR 40.05(10).

(b) Psychological Services.

1. Diagnostic services are an evaluative interview to determine a client's emotional and psychological disability for the purpose of developing a treatment plan.
2. Individual Therapy is a meeting between and eligible provider and the client to help to ameliorate problems, conflicts and disturbances.
3. Group Therapy is a treatment session conducted by an eligible provider for the application of psychotherapeutic or counseling techniques to a group of people each of whom manifests an emotional problem or disturbance. Groups are usually five people but are limited to ten clients.

4. Psychological Testing is performed with the use of standardized test instruments to evaluate aspects of a client's functioning, aptitudes and educational ability, cognitive processes, emotional conflicts and type and degree of psychopathology. All fees for psychological tests cover the complete cost of interviewing, testing, scoring, interpreting and writing reports of test outcomes.

(c) Fees. Rates of payment for psychological services are contained in 114.3 CMR 40.06 (11).

(d) Modifier -32 - Mandated Services. Services related to mandated consultation and/or related service (eg. PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier '32' to the basic procedure. [Use modifier -32 in addition to a psychotherapy code with medical evaluation and management to identify an initial/comprehensive office visit for the purpose of an injury assessment and in-depth evaluation of medical complaint(s) and present injury, past medical history, system review, physical examination, ordering of appropriate tests and procedures, and the preparation of an appropriate report as required under 452 CMR 1.13(1). If a confirmatory consultation is required, eg, by a third party payor, the modifier '-32', mandated services, should also be reported. The addition of modifier -32 to the selected code allows 115% of the allowable fee listed to be paid to the eligible provider.]

(12) Radiology

(a) Eligible Providers:

1. A licensed physician or licensed osteopath other than an intern, resident, or house officer who is authorized by the Board of Registration in Medicine in accordance with the provisions of M.G.L.c.112.
2. A licensed, registered podiatrist other than an intern, resident, or house officer who is authorized by the Board of Registration in Podiatry in accordance with the provisions of M.G.L.c.112, whose eligibility is limited to those procedures specified by the purchaser of the services.
3. An oral and/or maxillofacial surgeon who is authorized by the Board of Registration in Dentistry in accordance with the provisions of M.G.L.c.112.
4. A chiropractor licensed by the Board of Registration of Chiropractors under and meeting the requirements of M.G.L. c.112, §§ 89 through 97, whose eligibility is limited to those procedures within the scope and limitations of chiropractic medicine services.
5. A licensed, registered podiatrist other than an intern, resident, or house officer who is authorized by the Board of Registration in Podiatry in accordance with the provisions of M.G.L.c.112, whose eligibility is limited to those procedures specified by the purchaser of the services.

(b) Radiological Services. Services include diagnostic radiology (diagnostic imaging, diagnostic ultrasound and nuclear medicine). Most radiological services are comprised of a professional component and a technical component. The professional component is the physician's interpretation of the procedure, and the technical component is the equipment, supplies and technician's services used to perform the procedure. Fees and requirements for certain technical component services are contained in the regulatory section entitled Freestanding Diagnostic Services.

(c) Fees. Rates of payment for radiological services are contained in 114.3 CMR 40.06 (7).

(d) Contrast Media. Complete procedures, interventional radiological procedures or diagnostic studies involving injection of contrast media include all usual pre-injection and post-injection services, e.g. necessary local anesthesia, placement of needle catheter, injection of contrast media, supervision of the study, and interpretation of the results. Providers must determine whether the use of ionic or non-ionic contrast media is appropriate for the individual patient.

(13) Rehabilitation Clinic Services, Audiological Services, Restorative Services

(a) Eligible Provider.

1. A physical therapist (PT) who is currently licensed by the Board of Allied Health Professionals; or
2. A occupational therapist (OT) who is currently licensed by the Board of Allied Health Professionals; or
3. A speech therapist (ST) who is currently licensed by the Board of Speech and Language Pathology and Audiology; or
4. An audiologist who is currently licensed by the Board of Speech and Language Pathology and Audiology; or
5. A freestanding clinic providing rehabilitative services which is licensed by the Department of Public Health; or

6. A hospital outpatient clinic which is licensed by the Department of Public Health that is not subject to provisions contained in 114.1 CMR 41.00; or
7. Any speech and hearing center (proprietorship, partnership or corporation) which provides authorized speech or language services rendered by a qualified speech pathologist that does not bill separately from such facility for professional services rendered.
8. A chiropractor whose eligibility is limited to modalities within the range of codes 97012-97039 and therapeutic procedures within the range of codes 97110-97799.

(b) Rehabilitation, Restorative, Speech/Language Pathology and Audiological Services.
1. Rehabilitation services are comprehensive services deemed appropriate to the needs of a disabled person, in a program designed to achieve objectives of improved health and welfare with the realization of optimal physical, social and vocational potential.
2. Restorative services are PT, OT or ST services for the purpose of maximum reduction of physical and/or speech disability and restoration of optimal functional levels.
3. Speech/Language Pathology services include the evaluation and treatment of communicative disorders with regard to the functions of articulation (including aphasia and dysarthria, language, voice and fluency.)
4. Audiological services include testing related to the determination of hearing loss, evaluation of hearing aids, the prescription of hearing aid devices, and aural rehabilitation which includes lip-reading and auditory training. Complete audiological evaluation includes a routine audiological evaluation plus site of Lesion Testing (Impedance Testing and/or Recruitment Testing) as needed or recommended by a physician. A routine audio evaluation

(c) Fees. Rates of payment for restorative services are contained in 114.3 CMR 40.06 (12).

(d) Modifier -32 - Mandated Services. Services related to mandated consultation and/or related service (eg. PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier '32' to the basic procedure. [Use modifier -32 in addition to an Evaluation and Management (E/M) code to identify an initial/comprehensive office visit for the purpose of an injury assessment and in-depth evaluation of medical complaint(s) and present injury, past medical history, system review, physical examination, ordering of appropriate tests and procedures, and the preparation of an appropriate report as required under 452 CMR 1.13(1). If a confirmatory consultation is required, eg, by a third party payor, the modifier '-32', mandated services, should also be reported. The addition of modifier -32 to the E/M code allows 115% of the allowable fee listed to be paid to the eligible provider.]

(e) Functional Capacity Assessments. To report a functional capacity assessment (or Key functional assessment) use CPT code 97750 that may be billed up to a maximum of nine (9) units.

(f) Work Hardening and Work Conditioning. Work hardening and work conditioning are goal-oriented therapies designed to prepare injured workers for their return to work. Use CPT codes 97545 and 97456 to report these services. 97456 must be used in conjunction with 97545.

(g) Visits. In conjunction with pre-certification requirements issued by the D.I.A. under utilization review, a maximum of 18 visits within the first six weeks from the date of injury is allowed, unless additional visits are determined medically necessary by utilization review.

(h) Therapeutic Procedures. A maximum of 2 different therapeutic procedures (CPT codes 97110 through 97150) per treatment session is allowed.

(i) Modalities. A charge may be assessed for supportive services (CPT codes 97010 through97039) only in conjunction with a procedure performed during the course of the same visit. A maximum of three supportive services per visit is allowed. When determining the correct units allowed, round up to the nearest fifteen minute block of time (e.g. 1-15 minutes = 1 unit, and 16-30 minutes = 2 units). No charge shall be allowed for re-use of hot and cold packs (CPT codes 97010).

(j) Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS). Rates of payment for durable medical equipment, prosthetic/ orthotics and supplies are listed in 114.3 CMR 40.06(6) and subject to the provisions and guidelines contained in 114.3 CMR 40.05 (6).

(14) Surgery

(a) Eligible Providers:
1. A licensed physician or licensed osteopath other than an intern, resident, or house officer who is authorized by the Board of Registration in Medicine in accordance with the provisions of M.G.L.c.112.
2. A licensed, registered podiatrist other than an intern, resident, or house officer who is authorized by the Board of Registration in Medicine in accordance with the provisions of M.G.L.c.112, whose eligibility is limited to those procedures specified by the purchaser of the services.

3. licensed registered nurse who is authorized by the Board of Registration in Nursing in accordance with the provisions of M.G.L.c.112 to practice as a nurse practitioner (NP), limited to those procedures within the scope of NP services and subject to the rules of physician relationship for reimbursement defined by the Commonwealth's Nurse Practice Act. A licensed physician assistant (PA) who is authorized by the Board of Registration for Physician Assistants in accordance with the provisions of M.G.L.c.112 may not bill separately for services rendered.
4. A licensed dentist registered by the Board of Registration in Dentistry in accordance with the provisions of M.G.L. c.112.

(b) Payment for Surgical Procedures includes:
1. the immediate preoperative care performed on the same day as surgery, completion of hospital records and initiation of the treatment program;
2. local anesthesia, such as infiltration, metacarpal/digital or topical anesthesia,
3. the surgical procedure;
4. supplies and materials usually included in the office visit or procedure;
5. normal, uncomplicated, postoperative care performed on the same day as surgery at the facility.

(c) First Assistants. Non-physician providers who act as first assistants during surgical procedures must be identified by adding the modifier –81, Minimum Assistant Surgeon, to the usual procedure number and will be reimbursed at 15% of the fee stipulated in 114.3 CMR 40.05(16)(f).

(d) Fees. Rates of payment for surgical services are contained in 114.3 CMR 40.06 (8).

(e) Modifier -32 - Mandated Services. Services related to mandated consultation and/or related service (eg. PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier '32' to the basic procedure. [Use modifier -32 in addition to an Evaluation and Management (E/M) code to identify an initial/comprehensive office visit for the purpose of an injury assessment and in-depth evaluation of medical complaint(s) and present injury, past medical history, system review, physical examination, ordering of appropriate tests and procedures, and the preparation of an appropriate report as required under 452 CMR 1.13(1). If a confirmatory consultation is required, eg, by a third party payor, the modifier '-32', mandated services, should also be reported. The addition of modifier -32 to the E/M code allows 115% of the allowable fee listed to be paid to the eligible provider.]

(f) Payments for Qualified NPs and PAs. Payment to employers billing for eligible NPs and PAs as specified in 114.3 CMR 40.05(16)(a)3 is 85% of the fees contained in 114.3 CMR 40.06. Utilize the appropriate 2-digit modifier listed in 114.3 CMR 40.07 Appendix A to denote services rendered by a non-physician provider.

(g) Modifiers. See 114.3 CMR 40.07(1) Appendix A for a list of Level 1 CPT modifiers.

(h) Add-on Codes. 114.3 CMR 40.07(2) Appendix B lists procedures that are commonly carried out in addition to the primary procedure performed and must never be reported as stand-alone codes. These codes are exempt from the multiple procedure modifier '51'.

(i) Separate Procedures. 114.3 CMR 40.07(3) Appendix C lists procedures that are stand alone codes and are exempt from the multiple procedure modifier '51'.

40.06: Fees

SCHEDULE	PROVIDER/SERVICE TYPE	POLICY REFERENCE	PAGE NUMBER
(1)	Acupuncture	114.3 CMR 40.05 (1)	
(2)	Anesthesia	114.3 CMR 40.05 (2)	
(3)	Chiropractors	114.3 CMR 40.05 (3)	
(4)	Clinical Laboratories	114.3 CMR 40.05 (4)	
(5)	Dentists	114.3 CMR 40.05 (5)	
(6)	Durable Medical Equipment,, Prosthetics/ Orthotics, and Supplies(DMEPOS)	114.3 CMR 40.05 (6)	
(7)	• Freestanding Diagnostic Facilities • Radiology	• 114.3 CMR 40.05 (7) • 114.3 CMR 40.05 (12)	
(8)	• Freestanding Surgical Services • Surgery	• 114.3 CMR 40.05(8) • 114.3 CMR 40.05(14)	
(9)	Homemakers	114.3 CMR 40.05 (9)	
(10)	Medicine	114.3 CMR 40.05(10)	
(11)	Psychological Services	114.3 CMR 40.05 (11)	
(12)	Rehabilitation Clinics, Physical, Occupational, Speech Therapists, and Audiologists	114.3 CMR 40.05 (13)	

40.06(1) Acupuncture

Code	Fee	40.06(1) – Acupuncture Description
97039	9.03	Unlisted modality (specify type and time if constant attendance)
97124	17.37	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97139	12.47	Unlisted therapeutic procedure (specify)
97780	68.55	Acupuncture, one or more needles; without electrical stimulation
97781	78.83	Acupuncture, one or more needles; with electrical stimulation
97799	I.C.	Unlisted physical medicine/rehabilitation service or procedure
99080	24.85	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. (An additional report that is completed at the request of the patient's employer, insurer, utilization reviewer or agent subsequent to the completion of the required report under 452 CMR 1.13(1). This fee is for the treating provider's preparation time only. (per 15 minutes)) (Do not report 99080 in conjunction with codes using modifier -32 or with 99455, 99456 for the completion of Workmen's Compensation forms)
99201	29.26	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99202	50.85	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99203	76.11	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99204	107.50	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99205	135.43	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99211	17.97	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	30.83	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with

Code	Fee	40.06(1) – Acupuncture Description
		other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99213	42.23	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	65.36	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99215	94.43	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99371	24.85	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (eg, to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 15 minutes.)
99372	49.70	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); intermediate (eg, to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 30 minutes.)
99373	74.55	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); complex or lengthy (eg, lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 45 minutes.)

40.06(2) Anesthesia

PAYMENT *EQUALS* :	(TIME UNITS + BASE UNITS + MODIFYING UNITS)
	TIMES $19.86 (Rate per UNIT)

Code	Units	40.06(2) – Anesthesia Description
00100	5	Anesthesia for procedures on salivary glands, including biopsy
00102	6	Anesthesia for procedures involving plastic repair of cleft lip
00103	5	Anesthesia for reconstructive procedures of eyelid (eg, blepharoplasty, ptosis surgery)
00104	4	Anesthesia for electroconvulsive therapy
00120	5	Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified
00124	4	Anesthesia for procedures on external, middle, and inner ear including biopsy; otoscopy
00126	4	Anesthesia for procedures on external, middle, and inner ear including biopsy; tympanotomy
00140	5	Anesthesia for procedures on eye; not otherwise specified
00142	4	Anesthesia for procedures on eye; lens surgery
00144	6	Anesthesia for procedures on eye; corneal transplant
00145	6	Anesthesia for procedures on eye; vitreoretinal surgery
00147	4	Anesthesia for procedures on eye; iridectomy
00148	4	Anesthesia for procedures on eye; ophthalmoscopy
00160	5	Anesthesia for procedures on nose and accessory sinuses; not otherwise specified
00162	7	Anesthesia for procedures on nose and accessory sinuses; radical surgery
00164	4	Anesthesia for procedures on nose and accessory sinuses; biopsy, soft tissue
00170	5	Anesthesia for intraoral procedures, including biopsy; not otherwise specified
00172	6	Anesthesia for intraoral procedures, including biopsy; repair of cleft palate
00174	6	Anesthesia for intraoral procedures, including biopsy; excision of retropharyngeal tumor
00176	7	Anesthesia for intraoral procedures, including biopsy; radical surgery
00190	5	Anesthesia for procedures on facial bones or skull; not otherwise specified
00192	7	Anesthesia for procedures on facial bones or skull; radical surgery (including prognathism)
00210	11	Anesthesia for intracranial procedures; not otherwise specified
00212	5	Anesthesia for intracranial procedures; subdural taps
00214	9	Anesthesia for intracranial procedures; burr holes, including ventriculography
00215	9	Anesthesia for intracranial procedures; cranioplasty or elevation of depressed skull fracture, extradural (simple or compound)
00216	15	Anesthesia for intracranial procedures; vascular procedures
00218	13	Anesthesia for intracranial procedures; procedures in sitting position
00220	10	Anesthesia for intracranial procedures; cerebrospinal fluid shunting procedures
00222	6	Anesthesia for intracranial procedures; electrocoagulation of intracranial nerve
00300	5	Anesthesia for all procedures on the integumentary system, muscles and nerves of head, neck, and posterior trunk, not otherwise specified
00320	6	Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified, age 1 year or older
00322	3	Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck;

Code	Units	40.06(2) – Anesthesia Description
		needle biopsy of thyroid
00326	8	Anesthesia for all procedures on the larynx and trachea in children less than 1 year of age
00350	10	Anesthesia for procedures on major vessels of neck; not otherwise specified
00352	5	Anesthesia for procedures on major vessels of neck; simple ligation
00400	3	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified
00402	5	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; reconstructive procedures on breast (eg, reduction or augmentation mammoplasty, muscle flaps)
00404	5	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; radical or modified radical procedures on breast
00406	13	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; radical or modified radical procedures on breast with internal mammary node dissection
00410	4	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; electrical conversion of arrhythmias
00450	5	Anesthesia for procedures on clavicle and scapula; not otherwise specified
00452	6	Anesthesia for procedures on clavicle and scapula; radical surgery
00454	3	Anesthesia for procedures on clavicle and scapula; biopsy of clavicle
00470	6	Anesthesia for partial rib resection; not otherwise specified
00472	10	Anesthesia for partial rib resection; thoracoplasty (any type)
00474	13	Anesthesia for partial rib resection; radical procedures (eg, pectus excavatum)
00500	15	Anesthesia for all procedures on esophagus
00520	6	Anesthesia for closed chest procedures; (including bronchoscopy) not otherwise specified
00522	4	Anesthesia for closed chest procedures; needle biopsy of pleura
00524	4	Anesthesia for closed chest procedures; pneumocentesis
00528	8	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy not utilizing one lung ventilation
00529	11	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy utilizing one lung ventilation
00530	4	Anesthesia for permanent transvenous pacemaker insertion
00532	4	Anesthesia for access to central venous circulation
00534	7	Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator
00537	7	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation
00539	18	Anesthesia for tracheobronchial reconstruction
00540	12	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified
00541	15	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing one lung ventilation
00541	15	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing one lung ventilation
00542	5	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); decortication
00546	15	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); pulmonary resection with thoracoplasty
00548	17	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); intrathoracic procedures on the trachea and bronchi
00550	10	Anesthesia for sternal debridement

Code	Units	40.06(2) – Anesthesia Description
00560	15	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator
00562	20	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator
00563	25	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest
00566	25	Anesthesia for direct coronary artery bypass grafting without pump oxygenator
00580	20	Anesthesia for heart transplant or heart/lung transplant
00600	10	Anesthesia for procedures on cervical spine and cord; not otherwise specified
00604	13	Anesthesia for procedures on cervical spine and cord; procedures with patient in the sitting position
00620	10	Anesthesia for procedures on thoracic spine and cord; not otherwise specified
00622	13	Anesthesia for procedures on thoracic spine and cord; thoracolumbar sympathectomy
00630	8	Anesthesia for procedures in lumbar region; not otherwise specified
00632	7	Anesthesia for procedures in lumbar region; lumbar sympathectomy
00634	10	Anesthesia for procedures in lumbar region; chemonucleolysis
00635	4	Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture
00640	3	Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine
00640	3	Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine
00670	13	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)
00700	4	Anesthesia for procedures on upper anterior abdominal wall; not otherwise specified
00702	4	Anesthesia for procedures on upper anterior abdominal wall; percutaneous liver biopsy
00730	5	Anesthesia for procedures on upper posterior abdominal wall
00740	5	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum
00750	4	Anesthesia for hernia repairs in upper abdomen; not otherwise specified
00752	6	Anesthesia for hernia repairs in upper abdomen; lumbar and ventral (incisional) hernias and/or wound dehiscence
00754	7	Anesthesia for hernia repairs in upper abdomen; omphalocele
00756	7	Anesthesia for hernia repairs in upper abdomen; transabdominal repair of diaphragmatic hernia
00770	15	Anesthesia for all procedures on major abdominal blood vessels
00790	7	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified
00792	13	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; partial hepatectomy or management of liver hemorrhage (excluding liver biopsy)
00794	8	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; pancreatectomy, partial or total (eg, Whipple procedure)
00796	30	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)
00797	8	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity
00800	4	Anesthesia for procedures on lower anterior abdominal wall; not otherwise specified
00802	5	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy
00810	5	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum
00820	5	Anesthesia for procedures on lower posterior abdominal wall
00830	4	Anesthesia for hernia repairs in lower abdomen; not otherwise specified

Code	Units	40.06(2) – Anesthesia Description
00832	6	Anesthesia for hernia repairs in lower abdomen; ventral and incisional hernias
00834	5	Anesthesia for hernia repairs in the lower abdomen not otherwise specified, under 1 year of age
00836	6	Anesthesia for hernia repairs in the lower abdomen not otherwise specified, infants less than 37 weeks gestational age at birth and less than 50 weeks gestational age at time of surgery
00840	6	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
00842	4	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; amniocentesis
00844	7	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; abdominoperineal resection
00846	8	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; radical hysterectomy
00848	8	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; pelvic exenteration
00851	6	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection
00860	6	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified
00862	7	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal procedures, including upper 1/3 of ureter, or donor nephrectomy
00864	8	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; total cystectomy
00865	7	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; radical prostatectomy (suprapubic, retropubic)
00866	10	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; adrenalectomy
00868	10	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal transplant (recipient)
00870	5	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; cystolithotomy
00872	7	Anesthesia for lithotripsy, extracorporeal shock wave; with water bath
00873	5	Anesthesia for lithotripsy, extracorporeal shock wave; without water bath
00880	15	Anesthesia for procedures on major lower abdominal vessels; not otherwise specified
00882	10	Anesthesia for procedures on major lower abdominal vessels; inferior vena cava ligation
00902	5	Anesthesia for; anorectal procedure
00904	7	Anesthesia for; radical perineal procedure
00906	4	Anesthesia for; vulvectomy
00908	6	Anesthesia for; perineal prostatectomy
00910	3	Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified
00912	5	Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of bladder tumor(s)
00914	5	Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of prostate
00916	5	Anesthesia for transurethral procedures (including urethrocystoscopy); post-transurethral resection bleeding
00918	5	Anesthesia for transurethral procedures (including urethrocystoscopy); with fragmentation, manipulation and/or removal of ureteral calculus
00920	3	Anesthesia for procedures on male genitalia (including open urethral procedures); not otherwise specified
00921	3	Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral/bilateral
00922	6	Anesthesia for procedures on male genitalia (including open urethral procedures); seminal vesicles
00924	4	Anesthesia for procedures on male genitalia (including open urethral procedures); undescended testis, unilateral or bilateral

Code	Units	40.06(2) – Anesthesia Description
00926	4	Anesthesia for procedures on male genitalia (including open urethral procedures); radical orchiectomy, inguinal
00928	6	Anesthesia for procedures on male genitalia (including open urethral procedures); radical orchiectomy, abdominal
00930	4	Anesthesia for procedures on male genitalia (including open urethral procedures); orchiopexy, unilateral or bilateral
00932	4	Anesthesia for procedures on male genitalia (including open urethral procedures); complete amputation of penis
00934	6	Anesthesia for procedures on male genitalia (including open urethral procedures); radical amputation of penis with bilateral inguinal lymphadenectomy
00936	8	Anesthesia for procedures on male genitalia (including open urethral procedures); radical amputation of penis with bilateral inguinal and iliac lymphadenectomy
00938	4	Anesthesia for procedures on male genitalia (including open urethral procedures); insertion of penile prosthesis (perineal approach)
00940	3	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified
00942	4	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); colpotomy, vaginectomy, colporrhaphy, and open urethral procedures
00944	6	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy
00948	4	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); cervical cerclage
00950	5	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); culdoscopy
00952	4	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography
01112	5	Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest
01120	6	Anesthesia for procedures on bony pelvis
01130	3	Anesthesia for body cast application or revision
01140	15	Anesthesia for interpelviabdominal (hindquarter) amputation
01150	10	Anesthesia for radical procedures for tumor of pelvis, except hindquarter amputation
01160	4	Anesthesia for closed procedures involving symphysis pubis or sacroiliac joint
01170	8	Anesthesia for open procedures involving symphysis pubis or sacroiliac joint
01173	12	Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum
01180	3	Anesthesia for obturator neurectomy; extrapelvic
01190	4	Anesthesia for obturator neurectomy; intrapelvic
01200	4	Anesthesia for all closed procedures involving hip joint
01202	4	Anesthesia for arthroscopic procedures of hip joint
01210	6	Anesthesia for open procedures involving hip joint; not otherwise specified
01212	10	Anesthesia for open procedures involving hip joint; hip disarticulation
01214	8	Anesthesia for open procedures involving hip joint; total hip arthroplasty
01215	10	Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty
01220	4	Anesthesia for all closed procedures involving upper 2/3 of femur
01230	6	Anesthesia for open procedures involving upper 2/3 of femur; not otherwise specified
01232	5	Anesthesia for open procedures involving upper 2/3 of femur; amputation
01234	8	Anesthesia for open procedures involving upper 2/3 of femur; radical resection

Code	Units	40.06(2) – Anesthesia Description
01250	4	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of upper leg
01260	3	Anesthesia for all procedures involving veins of upper leg, including exploration
01270	8	Anesthesia for procedures involving arteries of upper leg, including bypass graft; not otherwise specified
01272	4	Anesthesia for procedures involving arteries of upper leg, including bypass graft; femoral artery ligation
01274	6	Anesthesia for procedures involving arteries of upper leg, including bypass graft; femoral artery embolectomy
01320	4	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of knee and/or popliteal area
01340	4	Anesthesia for all closed procedures on lower 1/3 of femur
01360	5	Anesthesia for all open procedures on lower 1/3 of femur
01380	3	Anesthesia for all closed procedures on knee joint
01382	3	Anesthesia for diagnostic arthroscopic procedures of knee joint
01390	3	Anesthesia for all closed procedures on upper ends of tibia, fibula, and/or patella
01392	4	Anesthesia for all open procedures on upper ends of tibia, fibula, and/or patella
01400	4	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01402	7	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty
01404	5	Anesthesia for open or surgical arthroscopic procedures on knee joint; disarticulation at knee
01420	3	Anesthesia for all cast applications, removal, or repair involving knee joint
01430	3	Anesthesia for procedures on veins of knee and popliteal area; not otherwise specified
01432	6	Anesthesia for procedures on veins of knee and popliteal area; arteriovenous fistula
01440	8	Anesthesia for procedures on arteries of knee and popliteal area; not otherwise specified
01442	8	Anesthesia for procedures on arteries of knee and popliteal area; popliteal thromboendarterectomy, with or without patch graft
01444	8	Anesthesia for procedures on arteries of knee and popliteal area; popliteal excision and graft or repair for occlusion or aneurysm
01462	3	Anesthesia for all closed procedures on lower leg, ankle, and foot
01464	3	Anesthesia for arthroscopic procedures of ankle and/or foot
01470	3	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; not otherwise specified
01472	5	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; repair of ruptured Achilles tendon, with or without graft
01474	5	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; gastrocnemius recession (eg, Strayer procedure)
01480	3	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
01482	4	Anesthesia for open procedures on bones of lower leg, ankle, and foot; radical resection (including below knee amputation)
01484	4	Anesthesia for open procedures on bones of lower leg, ankle, and foot; osteotomy or osteoplasty of tibia and/or fibula
01486	7	Anesthesia for open procedures on bones of lower leg, ankle, and foot; total ankle replacement
01490	3	Anesthesia for lower leg cast application, removal, or repair
01500	8	Anesthesia for procedures on arteries of lower leg, including bypass graft; not otherwise specified
01502	6	Anesthesia for procedures on arteries of lower leg, including bypass graft; embolectomy, direct or with catheter
01520	3	Anesthesia for procedures on veins of lower leg; not otherwise specified
01522	5	Anesthesia for procedures on veins of lower leg; venous thrombectomy, direct or with catheter
01610	5	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla

Code	Units	40.06(2) – Anesthesia Description
01620	4	Anesthesia for all closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint
01622	4	Anesthesia for diagnostic arthroscopic procedures of shoulder joint
01630	5	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01632	6	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; radical resection
01634	9	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; shoulder disarticulation
01636	15	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; interthoracoscapular (forequarter) amputation
01638	10	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement
01650	6	Anesthesia for procedures on arteries of shoulder and axilla; not otherwise specified
01652	10	Anesthesia for procedures on arteries of shoulder and axilla; axillary-brachial aneurysm
01654	8	Anesthesia for procedures on arteries of shoulder and axilla; bypass graft
01656	10	Anesthesia for procedures on arteries of shoulder and axilla; axillary-femoral bypass graft
01670	4	Anesthesia for all procedures on veins of shoulder and axilla
01680	3	Anesthesia for shoulder cast application, removal or repair; not otherwise specified
01682	4	Anesthesia for shoulder cast application, removal or repair; shoulder spica
01710	3	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified
01712	5	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenotomy, elbow to shoulder, open
01714	5	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenoplasty, elbow to shoulder
01716	5	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenodesis, rupture of long tendon of biceps
01730	3	Anesthesia for all closed procedures on humerus and elbow
01732	3	Anesthesia for diagnostic arthroscopic procedures of elbow joint
01740	4	Anesthesia for open or surgical arthroscopic procedures of the elbow; not otherwise specified
01742	5	Anesthesia for open or surgical arthroscopic procedures of the elbow; osteotomy of humerus
01744	5	Anesthesia for open or surgical arthroscopic procedures of the elbow; repair of nonunion or malunion of humerus
01756	6	Anesthesia for open or surgical arthroscopic procedures of the elbow; radical procedures
01758	5	Anesthesia for open or surgical arthroscopic procedures of the elbow; excision of cyst or tumor of humerus
01760	7	Anesthesia for open or surgical arthroscopic procedures of the elbow; total elbow replacement
01770	6	Anesthesia for procedures on arteries of upper arm and elbow; not otherwise specified
01772	6	Anesthesia for procedures on arteries of upper arm and elbow; embolectomy
01780	3	Anesthesia for procedures on veins of upper arm and elbow; not otherwise specified
01782	4	Anesthesia for procedures on veins of upper arm and elbow; phleborrhaphy
01810	3	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
01820	3	Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones
01829	3	Anesthesia for diagnostic arthroscopic procedures on the wrist
01830	3	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or

Code	Units	40.06(2) – Anesthesia Description
		hand joints; not otherwise specified
01832	6	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; total wrist replacement
01840	6	Anesthesia for procedures on arteries of forearm, wrist, and hand; not otherwise specified
01842	6	Anesthesia for procedures on arteries of forearm, wrist, and hand; embolectomy
01844	6	Anesthesia for vascular shunt, or shunt revision, any type (eg, dialysis)
01850	3	Anesthesia for procedures on veins of forearm, wrist, and hand; not otherwise specified
01852	4	Anesthesia for procedures on veins of forearm, wrist, and hand; phleborrhaphy
01860	3	Anesthesia for forearm, wrist, or hand cast application, removal, or repair
01905	5	Anesthesia for myelography, diskography, vertebroplasty
01916	6	Anesthesia for diagnostic arteriography/venography
01920	7	Anesthesia for cardiac catheterization including coronary angiography and ventriculography (not to include Swan-Ganz catheter)
01922	7	Anesthesia for non-invasive imaging or radiation therapy
01924	5	Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; not otherwise specified
01925	7	Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; carotid or coronary
01926	8	Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; intracranial, intracardiac, or aortic
01930	5	Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified
01931	7	Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrahepatic or portal circulation (eg, transcutaneous porto-caval shunt (TIPS))
01932	6	Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrathoracic or jugular
01933	7	Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intracranial
01951	3	Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; less than four percent total body surface area
01952	5	Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; between four and nine percent of total body surface area
01953	1	Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; each additional nine percent total body surface area or part thereof (List separately in addition to code for primary procedure)
01958	5	Anesthesia for external cephalic version procedure
01960	5	Anesthesia for vaginal delivery only
01961	7	Anesthesia for cesarean delivery only
01962	8	Anesthesia for urgent hysterectomy following delivery
01963	8	Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care
01964	4	Anesthesia for abortion procedures
01967	5	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)

Code	Units	40.06(2) – Anesthesia Description
01968	2	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)
01969	5	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)
01990	7	Physiological support for harvesting of organ(s) from brain-dead patient
01991	3	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position
01992	5	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position
01995	5	Regional intravenous administration of local anesthetic agent or other medication (upper or lower extremity)
01996	3	Daily hospital management of epidural or subarachnoid continuous drug administration
01999	0	Unlisted anesthesia procedure(s)

40.06(3) Chiropractors

Code	Fee	40.06(3) – Chiropractic Description
98940	29.21	Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941	37.78	Chiropractic manipulative treatment (CMT); spinal, three to four regions
98942	46.73	Chiropractic manipulative treatment (CMT); spinal, five regions
98943	28.04	Chiropractic manipulative treatment (CMT); extraspinal, one or more regions
99080	24.85	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. (An additional report that is completed at the request of the patient's employer, insurer, utilization reviewer or agent subsequent to the completion of the required report under 452 CMR 1.13(1). This fee is for the treating provider's preparation time only. (per 15 minutes)) (Do not report 99080 in conjunction with codes using modifier -32 or with 99455, 99456 for the completion of Workmen's Compensation forms)
99201	29.26	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99202	50.85	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99203	76.11	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99204	107.50	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99211	17.97	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	30.83	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99213	42.23	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

Code	Fee	40.06(3) – Chiropractic Description
		Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	65.36	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99371	24.85	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (eg, to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 15 minutes.)
99372	49.70	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); intermediate (eg, to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 30 minutes.)
99373	74.55	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); complex or lengthy (eg, lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 45 minutes.)
99456	I.C.	Work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report.

40.06(4) Clinical Laboratories

Code	Fee	40.06(4) – Clinical Lab Description
78267	10.98	Urea breath test, C-14; acquisition for analysis
78268	94.11	Urea breath test, C-14; analysis
80048	11.83	Basic metabolic panel This panel must include the following: Calcium (82310) Carbon dioxide (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)
80051	9.80	Electrolyte panel This panel must include the following: Carbon dioxide (82374) Chloride (82435) Potassium (84132) Sodium (84295)
80053	14.77	Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)
80061	18.72	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)
80061	18.72	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)
80069	12.13	Renal function panel This panel must include the following: Albumin (82040) Calcium (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphorus inorganic (phosphate) (84100) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)
80074	62.84	Acute hepatitis panel This panel must include the following: Hepatitis A antibody (HAAb), IgM antibody (86709) Hepatitis B core antibody (HBcAb), IgM antibody (86705) Hepatitis B surface antigen (HBsAg) (87340) Hepatitis C antibody (86803)
80076	11.42	Hepatic function panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Bilirubin, direct (82248) Phosphatase, alkaline (84075) Protein, total (84155) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450)
80100	16.32	Drug screen, qualitative; multiple drug classes chromatographic method, each procedure
80101	19.24	Drug screen, qualitative; single drug class method (eg, immunoassay, enzyme assay), each drug class
80101	19.24	Drug screen, qualitative; single drug class method (eg, immunoassay, enzyme assay), each drug class
80102	18.51	Drug confirmation, each procedure
80150	21.06	Amikacin
80152	25.01	Amitriptyline
80154	25.84	Benzodiazepines
80156	20.34	Carbamazepine; total
80157	18.52	Carbamazepine; free
80158	25.23	Cyclosporine
80160	24.05	Desipramine
80162	18.55	Digoxin
80164	18.93	Dipropylacetic acid (valproic acid)
80166	21.66	Doxepin
80168	22.83	Ethosuximide
80170	22.90	Gentamicin
80172	22.76	Gold
80173	20.34	Haloperidol
80174	24.05	Imipramine

Code	Fee	40.06(4) – Clinical Lab Description
80176	20.52	Lidocaine
80178	9.24	Lithium
80182	18.93	Nortriptyline
80184	16.01	Phenobarbital
80185	18.52	Phenytoin; total
80186	19.23	Phenytoin; free
80188	23.18	Primidone
80190	23.41	Procainamide;
80192	23.41	Procainamide; with metabolites (eg, n-acetyl procainamide)
80194	20.39	Quinidine
80196	9.92	Salicylate
80197	10.18	Tacrolimus
80198	19.77	Theophylline
80200	22.52	Tobramycin
80201	16.66	Topiramate
80202	18.93	Vancomycin
80299	19.13	Quantitation of drug, not elsewhere specified
80400	45.56	ACTH stimulation panel; for adrenal insufficiency This panel must include the following: Cortisol (82533 x 2)
80402	121.46	ACTH stimulation panel; for 21 hydroxylase deficiency This panel must include the following: Cortisol (82533 x 2) 17 hydroxyprogesterone (83498 x 2)
80406	106.06	ACTH stimulation panel; for 3 beta-hydroxydehydrogenase deficiency This panel must include the following: Cortisol (82533 x 2) 17 hydroxypregnenolone (84143 x 2)
80408	175.34	Aldosterone suppression evaluation panel (eg, saline infusion) This panel must include the following: Aldosterone (82088 x 2) Renin (84244 x 2)
80410	112.23	Calcitonin stimulation panel (eg, calcium, pentagastrin) This panel must include the following: Calcitonin (82308 x 3)
80412	460.50	Corticotropic releasing hormone (CRH) stimulation panel This panel must include the following: Cortisol (82533 x 6) Adrenocorticotropic hormone (ACTH) (82024 x 6)
80414	72.16	Chorionic gonadotropin stimulation panel; testosterone response This panel must include the following: Testosterone (84403 x 2 on three pooled blood samples)
80415	78.08	Chorionic gonadotropin stimulation panel; estradiol response This panel must include the following: Estradiol (82670 x 2 on three pooled blood samples)
80416	184.38	Renal vein renin stimulation panel (eg, captopril) This panel must include the following: Renin (84244 x 6)
80417	61.46	Peripheral vein renin stimulation panel (eg, captopril) This panel must include the following: Renin (84244 x 2)
80418	809.76	Combined rapid anterior pituitary evaluation panel This panel must include the following: Adrenocorticotropic hormone (ACTH) (82024 x 4) Luteinizing hormone (LH) (83002 x 4) Follicle stimulating hormone (FSH) (83001 x 4) Prolactin (84146 x 4) Human growth hormone (HGH) (83003 x 4) Cortisol (82533 x 4) Thyroid stimulating hormone (TSH) (84443 x 4)
80420	100.64	Dexamethasone suppression panel, 48 hour This panel must include the following: Free cortisol, urine (82530 x 2) Cortisol (82533 x 2) Volume measurement for timed collection (81050 x 2)
80422	64.38	Glucagon tolerance panel; for insulinoma This panel must include the following: Glucose (82947 x 3) Insulin (83525 x 3)
80424	70.56	Glucagon tolerance panel; for pheochromocytoma This panel must include the following: Catecholamines, fractionated (82384 x 2)

Code	Fee	40.06(4) – Clinical Lab Description
80426	207.40	Gonadotropin releasing hormone stimulation panel This panel must include the following: Follicle stimulating hormone (FSH) (83001 x 4) Luteinizing hormone (LH) (83002 x 4)
80428	93.16	Growth hormone stimulation panel (eg, arginine infusion, l-dopa administration) This panel must include the following: Human growth hormone (HGH) (83003 x 4)
80430	109.60	Growth hormone suppression panel (glucose administration) This panel must include the following: Glucose (82947 x 3) Human growth hormone (HGH) (83003 x 4)
80432	188.73	Insulin-induced C-peptide suppression panel This panel must include the following: Insulin (83525) C-peptide (84681 x 5) Glucose (82947 x 5)
80434	141.30	Insulin tolerance panel; for ACTH insufficiency This panel must include the following: Cortisol (82533 x 5) Glucose (82947 x 5)
80435	143.85	Insulin tolerance panel; for growth hormone deficiency This panel must include the following: Glucose (82947 x 5) Human growth hormone (HGH) (83003 x 5)
80436	127.36	Metyrapone panel This panel must include the following: Cortisol (82533 x 2) 11 deoxycortisol (82634 x 2)
80438	70.41	Thyrotropin releasing hormone (TRH) stimulation panel; one hour This panel must include the following: Thyroid stimulating hormone (TSH) (84443 x 3)
80439	93.88	Thyrotropin releasing hormone (TRH) stimulation panel; two hour This panel must include the following: Thyroid stimulating hormone (TSH) (84443 x 4)
80440	81.24	Thyrotropin releasing hormone (TRH) stimulation panel; for hyperprolactinemia This panel must include the following: Prolactin (84146 x 3)
81000	4.43	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	4.43	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81002	3.57	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
81003	3.14	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
81003	3.14	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
81005	3.03	Urinalysis; qualitative or semiquantitative, except immunoassays
81007	3.59	Urinalysis; bacteriuria screen, except by culture or dipstick
81007	3.59	Urinalysis; bacteriuria screen, except by culture or dipstick
81015	4.24	Urinalysis; microscopic only
81020	5.15	Urinalysis; two or three glass test
81025	8.84	Urine pregnancy test, by visual color comparison methods
81050	4.19	Volume measurement for timed collection, each
82000	17.31	Acetaldehyde, blood
82003	28.28	Acetaminophen
82009	6.31	Acetone or other ketone bodies, serum; qualitative
82010	11.42	Acetone or other ketone bodies, serum; quantitative
82010	11.42	Acetone or other ketone bodies, serum; quantitative
82013	15.61	Acetylcholinesterase
82016	19.37	Acylcarnitines; qualitative, each specimen

Code	Fee	40.06(4) – Clinical Lab Description
82017	14.94	Acylcarnitines; quantitative, each specimen
82024	53.97	Adrenocorticotropic hormone (ACTH)
82030	36.05	Adenosine, 5-monophosphate, cyclic (cyclic AMP)
82040	6.92	Albumin; serum
82042	7.23	Albumin; urine or other source, quantitative, each specimen
82043	7.56	Albumin; urine, microalbumin, quantitative
82044	6.39	Albumin; urine, microalbumin, semiquantitative (eg, reagent strip assay)
82044	6.39	Albumin; urine, microalbumin, semiquantitative (eg, reagent strip assay)
82055	15.10	Alcohol (ethanol); any specimen except breath
82055	15.10	Alcohol (ethanol); any specimen except breath
82075	16.84	Alcohol (ethanol); breath
82085	13.56	Aldolase
82088	56.94	Aldosterone
82101	38.96	Alkaloids, urine, quantitative
82103	18.77	Alpha-1-antitrypsin; total
82104	20.20	Alpha-1-antitrypsin; phenotype
82105	23.44	Alpha-fetoprotein; serum
82106	23.44	Alpha-fetoprotein; amniotic fluid
82108	35.60	Aluminum
82120	5.25	Amines, vaginal fluid, qualitative
82120	5.25	Amines, vaginal fluid, qualitative
82127	19.37	Amino acids; single, qualitative, each specimen
82128	19.37	Amino acids; multiple, qualitative, each specimen
82131	23.57	Amino acids; single, quantitative, each specimen
82135	23.00	Aminolevulinic acid, delta (ALA)
82136	14.94	Amino acids, 2 to 5 amino acids, quantitative, each specimen
82139	14.94	Amino acids, 6 or more amino acids, quantitative, each specimen
82140	20.36	Ammonia
82143	9.61	Amniotic fluid scan (spectrophotometric)
82145	21.72	Amphetamine or methamphetamine
82150	9.06	Amylase
82154	40.29	Androstanediol glucuronide
82157	40.90	Androstenedione
82160	34.94	Androsterone
82163	25.16	Angiotensin II
82164	20.39	Angiotensin I - converting enzyme (ACE)
82172	21.65	Apolipoprotein, each
82175	26.51	Arsenic
82180	13.81	Ascorbic acid (Vitamin C), blood
82190	7.61	Atomic absorption spectroscopy, each analyte
82205	16.01	Barbiturates, not elsewhere specified
82232	22.61	Beta-2 microglobulin
82239	23.94	Bile acids; total
82240	37.13	Bile acids; cholylglycine

Code	Fee	40.06(4) – Clinical Lab Description
82247	7.02	Bilirubin; total
82248	7.02	Bilirubin; direct
82252	6.35	Bilirubin; feces, qualitative
82261	14.94	Biotinidase, each specimen
82270	4.54	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, 1-3 simultaneous determinations
82273	4.54	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; other sources
82273	4.54	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; other sources
82274	18.09	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
82274	18.09	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
82286	9.62	Bradykinin
82300	32.33	Cadmium
82306	41.36	Calcifediol (25-OH Vitamin D-3)
82307	45.02	Calciferol (Vitamin D)
82308	37.41	Calcitonin
82310	7.20	Calcium; total
82330	19.09	Calcium; ionized
82331	7.23	Calcium; after calcium infusion test
82340	8.43	Calcium; urine quantitative, timed specimen
82355	16.17	Calculus; qualitative analysis
82360	17.99	Calculus; quantitative analysis, chemical
82365	18.01	Calculus; infrared spectroscopy
82370	17.51	Calculus; x-ray diffraction
82373	25.23	Carbohydrate deficient transferrin
82374	6.83	Carbon dioxide (bicarbonate)
82375	17.22	Carbon monoxide, (carboxyhemoglobin); quantitative
82376	8.37	Carbon monoxide, (carboxyhemoglobin); qualitative
82378	26.51	Carcinoembryonic antigen (CEA)
82379	14.94	Carnitine (total and free), quantitative, each specimen
82380	12.89	Carotene
82382	24.02	Catecholamines; total urine
82383	35.01	Catecholamines; blood
82384	35.28	Catecholamines; fractionated
82387	29.07	Cathepsin-D
82390	15.01	Ceruloplasmin
82397	14.94	Chemiluminescent assay
82415	17.70	Chloramphenicol
82435	6.42	Chloride; blood
82436	7.02	Chloride; urine
82438	6.83	Chloride; other source
82441	8.38	Chlorinated hydrocarbons, screen
82465	6.08	Cholesterol, serum or whole blood, total
82465	6.08	Cholesterol, serum or whole blood, total

Code	Fee	40.06(4) – Clinical Lab Description
82480	11.01	Cholinesterase; serum
82482	10.74	Cholinesterase; RBC
82485	28.85	Chondroitin B sulfate, quantitative
82486	25.23	Chromatography, qualitative; column (eg, gas liquid or HPLC), analyte not elsewhere specified
82487	22.30	Chromatography, qualitative; paper, 1-dimensional, analyte not elsewhere specified
82488	29.85	Chromatography, qualitative; paper, 2-dimensional, analyte not elsewhere specified
82489	25.84	Chromatography, qualitative; thin layer, analyte not elsewhere specified
82491	25.23	Chromatography, quantitative, column (eg, gas liquid or HPLC); single analyte not elsewhere specified, single stationary and mobile phase
82492	25.23	Chromatography, quantitative, column (eg, gas liquid or HPLC); multiple analytes, single stationary and mobile phase
82495	28.34	Chromium
82507	38.85	Citrate
82520	21.17	Cocaine or metabolite
82523	17.81	Collagen cross links, any method
82523	17.81	Collagen cross links, any method
82525	17.34	Copper
82528	31.45	Corticosterone
82530	23.35	Cortisol; free
82533	22.78	Cortisol; total
82540	6.48	Creatine
82541	25.23	Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; qualitative, single stationary and mobile phase
82542	25.23	Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; quantitative, single stationary and mobile phase
82543	25.23	Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; stable isotope dilution, single analyte, quantitative, single stationary and mobile phase
82544	25.23	Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; stable isotope dilution, multiple analytes, quantitative, single stationary and mobile phase
82550	9.10	Creatine kinase (CK), (CPK); total
82552	18.71	Creatine kinase (CK), (CPK); isoenzymes
82553	10.83	Creatine kinase (CK), (CPK); MB fraction only
82554	10.68	Creatine kinase (CK), (CPK); isoforms
82565	7.16	Creatinine; blood
82570	7.23	Creatinine; other source
82570	7.23	Creatinine; other source
82575	13.20	Creatinine; clearance
82585	8.11	Cryofibrinogen
82595	9.04	Cryoglobulin, qualitative or semi-quantitative (eg, cryocrit)
82600	27.11	Cyanide
82607	20.91	Cyanocobalamin (Vitamin B-12);
82608	20.01	Cyanocobalamin (Vitamin B-12); unsaturated binding capacity
82615	11.41	Cystine and homocystine, urine, qualitative
82626	35.31	Dehydroepiandrosterone (DHEA)
82627	31.07	Dehydroepiandrosterone-sulfate (DHEA-S)

Code	Fee	40.06(4) – Clinical Lab Description
82633	43.28	Desoxycorticosterone, 11-
82634	40.90	Deoxycortisol, 11-
82638	17.11	Dibucaine number
82646	28.85	Dihydrocodeinone
82649	35.91	Dihydromorphinone
82651	36.07	Dihydrotestosterone (DHT)
82652	53.78	Dihydroxyvitamin D, 1,25-
82654	19.34	Dimethadione
82657	25.23	Enzyme activity in blood cells, cultured cells, or tissue, not elsewhere specified; nonradioactive substrate, each specimen
82658	25.23	Enzyme activity in blood cells, cultured cells, or tissue, not elsewhere specified; radioactive substrate, each specimen
82664	48.00	Electrophoretic technique, not elsewhere specified
82666	29.50	Epiandrosterone
82668	26.26	Erythropoietin
82670	39.04	Estradiol
82671	45.13	Estrogens; fractionated
82672	30.30	Estrogens; total
82677	25.91	Estriol
82679	34.88	Estrone
82679	34.88	Estrone
82690	24.15	Ethchlorvynol
82693	20.82	Ethylene glycol
82696	32.95	Etiocholanolone
82705	7.11	Fat or lipids, feces; qualitative
82710	23.47	Fat or lipids, feces; quantitative
82715	24.05	Fat differential, feces, quantitative
82725	18.60	Fatty acids, nonesterified
82726	25.23	Very long chain fatty acids
82728	19.03	Ferritin
82731	89.99	Fetal fibronectin, cervicovaginal secretions, semi-quantitative
82735	25.91	Fluoride
82742	27.66	Flurazepam
82746	20.54	Folic acid; serum
82747	21.91	Folic acid; RBC
82757	24.24	Fructose, semen
82759	30.01	Galactokinase, RBC
82760	15.64	Galactose
82775	29.43	Galactose-1-phosphate uridyl transferase; quantitative
82776	11.71	Galactose-1-phosphate uridyl transferase; screen
82784	10.39	Gammaglobulin; IgA, IgD, IgG, IgM, each
82785	23.01	Gammaglobulin; IgE
82787	5.15	Gammaglobulin; immunoglobulin subclasses, (IgG1, 2, 3, or 4), each
82800	11.83	Gases, blood, pH only

Code	Fee	40.06(4) – Clinical Lab Description
82803	27.04	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation);
82805	39.65	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation); with O2 saturation, by direct measurement, except pulse oximetry
82810	12.20	Gases, blood, O2 saturation only, by direct measurement, except pulse oximetry
82820	10.76	Hemoglobin-oxygen affinity (pO2 for 50% hemoglobin saturation with oxygen)
82926	7.61	Gastric acid, free and total, each specimen
82928	9.15	Gastric acid, free or total; each specimen
82938	24.72	Gastrin after secretin stimulation
82941	24.64	Gastrin
82943	19.97	Glucagon
82945	5.48	Glucose, body fluid, other than blood
82946	21.06	Glucagon tolerance test
82947	5.48	Glucose; quantitative, blood (except reagent strip)
82947	5.48	Glucose; quantitative, blood (except reagent strip)
82948	3.57	Glucose; blood, reagent strip
82950	6.64	Glucose; post glucose dose (includes glucose)
82950	6.64	Glucose; post glucose dose (includes glucose)
82951	17.99	Glucose; tolerance test (GTT), three specimens (includes glucose)
82951	17.99	Glucose; tolerance test (GTT), three specimens (includes glucose)
82952	4.02	Glucose; tolerance test, each additional beyond three specimens
82952	4.02	Glucose; tolerance test, each additional beyond three specimens
82953	21.16	Glucose; tolbutamide tolerance test
82955	12.47	Glucose-6-phosphate dehydrogenase (G6PD); quantitative
82960	8.11	Glucose-6-phosphate dehydrogenase (G6PD); screen
82962	3.27	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use
82963	30.01	Glucosidase, beta
82965	10.80	Glutamate dehydrogenase
82975	22.13	Glutamine (glutamic acid amide)
82977	10.06	Glutamyltransferase, gamma (GGT)
82978	19.91	Glutathione
82979	9.62	Glutathione reductase, RBC
82980	25.60	Glutethimide
82985	21.06	Glycated protein
82985	21.06	Glycated protein
83001	25.97	Gonadotropin; follicle stimulating hormone (FSH)
83001	25.97	Gonadotropin; follicle stimulating hormone (FSH)
83002	25.88	Gonadotropin; luteinizing hormone (LH)
83002	25.88	Gonadotropin; luteinizing hormone (LH)
83003	23.29	Growth hormone, human (HGH) (somatotropin)
83008	23.45	Guanosine monophosphate (GMP), cyclic
83010	17.58	Haptoglobin; quantitative
83012	24.02	Haptoglobin; phenotypes
83013	94.11	Helicobacter pylori; analysis for urease activity, non-radioactive isotope
83014	10.98	Helicobacter pylori; drug administration and sample collection

Code	Fee	40.06(4) – Clinical Lab Description
83015	26.31	Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); screen
83018	30.68	Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); quantitative, each
83020	17.99	Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F)
83021	25.23	Hemoglobin fractionation and quantitation; chromatography (eg, A2, S, C, and/or F)
83026	3.30	Hemoglobin; by copper sulfate method, non-automated
83030	11.56	Hemoglobin; F (fetal), chemical
83033	8.33	Hemoglobin; F (fetal), qualitative
83036	13.56	Hemoglobin; glycated
83036	13.56	Hemoglobin; glycated
83045	6.93	Hemoglobin; methemoglobin, qualitative
83050	10.23	Hemoglobin; methemoglobin, quantitative
83051	10.21	Hemoglobin; plasma
83055	6.87	Hemoglobin; sulfhemoglobin, qualitative
83060	11.56	Hemoglobin; sulfhemoglobin, quantitative
83065	9.62	Hemoglobin; thermolabile
83068	11.83	Hemoglobin; unstable, screen
83069	5.51	Hemoglobin; urine
83070	6.64	Hemosiderin; qualitative
83071	9.61	Hemosiderin; quantitative
83080	14.94	b-Hexosaminidase, each assay
83088	41.26	Histamine
83090	23.57	Homocystine
83150	27.04	Homovanillic acid (HVA)
83491	24.47	Hydroxycorticosteroids, 17- (17-OHCS)
83497	18.01	Hydroxyindolacetic acid, 5-(HIAA)
83498	37.95	Hydroxyprogesterone, 17-d
83499	35.22	Hydroxyprogesterone, 20-
83500	31.65	Hydroxyproline; free
83505	33.96	Hydroxyproline; total
83516	16.01	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; multiple step method
83518	10.68	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; single step method (eg, reagent strip)
83518	10.68	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; single step method (eg, reagent strip)
83519	18.88	Immunoassay, analyte, quantitative; by radiopharmaceutical technique (eg, RIA)
83520	18.09	Immunoassay, analyte, quantitative; not otherwise specified
83525	15.98	Insulin; total
83527	17.68	Insulin; free
83528	22.22	Intrinsic factor
83540	9.05	Iron
83550	12.21	Iron binding capacity
83570	9.61	Isocitric dehydrogenase (IDH)
83582	19.80	Ketogenic steroids, fractionation

Code	Fee	40.06(4) – Clinical Lab Description
83586	17.89	Ketosteroids, 17- (17-KS); total
83593	36.75	Ketosteroids, 17- (17-KS); fractionation
83605	14.92	Lactate (lactic acid)
83605	14.92	Lactate (lactic acid)
83615	8.44	Lactate dehydrogenase (LD), (LDH);
83625	17.88	Lactate dehydrogenase (LD), (LDH); isoenzymes, separation and quantitation
83632	28.24	Lactogen, human placental (HPL) human chorionic somatomammotropin
83633	7.69	Lactose, urine; qualitative
83634	16.10	Lactose, urine; quantitative
83655	16.91	Lead
83661	30.71	Fetal lung maturity assessment; lecithin sphingomyelin (L/S) ratio
83662	26.43	Fetal lung maturity assessment; foam stability test
83663	26.43	Fetal lung maturity assessment; fluorescence polarization
83664	26.43	Fetal lung maturity assessment; lamellar body density
83670	11.77	Leucine aminopeptidase (LAP)
83690	9.62	Lipase
83715	15.73	Lipoprotein, blood; electrophoretic separation and quantitation
83716	34.68	Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg, electrophoresis, nuclear magnetic resonance, ultracentrifugation)
83718	11.44	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
83718	11.44	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
83719	16.26	Lipoprotein, direct measurement; direct measurement, VLDL cholesterol
83721	12.81	Lipoprotein, direct measurement; direct measurement, LDL cholesterol
83727	24.02	Luteinizing releasing factor (LRH)
83735	9.36	Magnesium
83775	9.75	Malate dehydrogenase
83785	34.36	Manganese
83788	25.23	Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; qualitative, each specimen
83789	25.23	Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; quantitative, each specimen
83805	24.63	Meprobamate
83825	22.72	Mercury, quantitative
83835	23.67	Metanephrines
83840	22.81	Methadone
83857	10.97	Methemalbumin
83858	20.71	Methsuximide
83864	27.82	Mucopolysaccharides, acid; quantitative
83866	13.76	Mucopolysaccharides, acid; screen
83872	8.19	Mucin, synovial fluid (Ropes test)
83873	24.04	Myelin basic protein, cerebrospinal fluid
83874	18.04	Myoglobin
83880	47.43	Natriuretic peptide
83883	15.86	Nephelometry, each analyte not elsewhere specified

Code	Fee	40.06(4) – Clinical Lab Description
83885	34.23	Nickel
83887	33.09	Nicotine
83890	5.60	Molecular diagnostics; molecular isolation or extraction
83891	5.60	Molecular diagnostics; isolation or extraction of highly purified nucleic acid
83892	5.60	Molecular diagnostics; enzymatic digestion
83893	5.60	Molecular diagnostics; dot/slot blot production
83894	5.60	Molecular diagnostics; separation by gel electrophoresis (eg, agarose, polyacrylamide)
83896	5.60	Molecular diagnostics; nucleic acid probe, each
83897	5.60	Molecular diagnostics; nucleic acid transfer (eg, Southern, Northern)
83898	6.10	Molecular diagnostics; amplification of patient nucleic acid (eg, PCR, LCR), single primer pair, each primer pair
83901	6.10	Molecular diagnostics; amplification of patient nucleic acid, multiplex, each multiplex reaction
83902	5.75	Molecular diagnostics; reverse transcription
83903	6.10	Molecular diagnostics; mutation scanning, by physical properties (eg, single strand conformational polymorphisms (SSCP), heteroduplex, denaturing gradient gel electrophoresis (DGGE), RNA'ase A), single segment, each
83904	6.10	Molecular diagnostics; mutation identification by sequencing, single segment, each segment
83905	6.10	Molecular diagnostics; mutation identification by allele specific transcription, single segment, each segment
83906	6.10	Molecular diagnostics; mutation identification by allele specific translation, single segment, each segment
83912	5.60	Molecular diagnostics; interpretation and report
83915	15.58	Nucleotidase 5-
83916	28.09	Oligoclonal immune (oligoclonal bands)
83918	23.00	Organic acids; total, quantitative, each specimen
83919	23.00	Organic acids; qualitative, each specimen
83921	23.00	Organic acid, single, quantitative
83925	27.19	Opiates, (eg, morphine, meperidine)
83930	9.24	Osmolality; blood
83935	9.52	Osmolality; urine
83937	41.71	Osteocalcin (bone g1a protein)
83945	17.99	Oxalate
83950	89.99	Oncoprotein, HER-2/neu
83970	57.67	Parathormone (parathyroid hormone)
83986	5.00	pH, body fluid, except blood
83986	5.00	pH, body fluid, except blood
83992	20.54	Phencyclidine (PCP)
84022	21.76	Phenothiazine
84030	7.69	Phenylalanine (PKU), blood
84035	5.11	Phenylketones, qualitative
84060	10.32	Phosphatase, acid; total
84061	10.39	Phosphatase, acid; forensic examination
84066	13.50	Phosphatase, acid; prostatic
84075	7.23	Phosphatase, alkaline;
84078	10.20	Phosphatase, alkaline; heat stable (total not included)

Code	Fee	40.06(4) – Clinical Lab Description
84080	20.66	Phosphatase, alkaline; isoenzymes
84081	23.09	Phosphatidylglycerol
84085	9.42	Phosphogluconate, 6-, dehydrogenase, RBC
84087	14.42	Phosphohexose isomerase
84100	6.63	Phosphorus inorganic (phosphate);
84105	7.23	Phosphorus inorganic (phosphate); urine
84106	5.99	Porphobilinogen, urine; qualitative
84110	11.80	Porphobilinogen, urine; quantitative
84119	10.60	Porphyrins, urine; qualitative
84120	20.55	Porphyrins, urine; quantitation and fractionation
84126	35.59	Porphyrins, feces; quantitative
84127	10.60	Porphyrins, feces; qualitative
84132	6.42	Potassium; serum
84133	6.01	Potassium; urine
84134	20.38	Prealbumin
84135	26.73	Pregnanediol
84138	26.46	Pregnanetriol
84140	28.89	Pregnenolone
84143	30.25	17-hydroxypregnenolone
84144	29.15	Progesterone
84146	27.08	Prolactin
84150	34.88	Prostaglandin, each
84152	25.70	Prostate specific antigen (PSA); complexed (direct measurement)
84153	25.70	Prostate specific antigen (PSA); total
84154	25.70	Prostate specific antigen (PSA); free
84155	5.12	Protein, total, except by refractometry; serum
84156	5.12	Protein, total, except by refractometry; urine
84157	5.12	Protein, total, except by refractometry; other source (eg, synovial fluid, cerebrospinal fluid)
84160	7.23	Protein, total, by refractometry, any source
84165	15.01	Protein; electrophoretic fractionation and quantitation
84181	23.80	Protein; Western Blot, with interpretation and report, blood or other body fluid
84182	25.15	Protein; Western Blot, with interpretation and report, blood or other body fluid, immunological probe for band identification, each
84202	20.05	Protoporphyrin, RBC; quantitative
84203	12.03	Protoporphyrin, RBC; screen
84206	24.89	Proinsulin
84207	37.96	Pyridoxal phosphate (Vitamin B-6)
84210	15.17	Pyruvate
84220	13.18	Pyruvate kinase
84228	16.26	Quinine
84233	89.99	Receptor assay; estrogen
84234	90.64	Receptor assay; progesterone
84235	73.12	Receptor assay; endocrine, other than estrogen or progesterone (specify hormone)
84238	51.09	Receptor assay; non-endocrine (eg, acetylcholine) (specify receptor)

Code	Fee	40.06(4) – Clinical Lab Description
84244	30.73	Renin
84252	28.28	Riboflavin (Vitamin B-2)
84255	35.67	Selenium
84260	43.28	Serotonin
84270	30.36	Sex hormone binding globulin (SHBG)
84275	18.77	Sialic acid
84285	32.90	Silica
84295	6.72	Sodium; serum
84300	6.79	Sodium; urine
84302	6.79	Sodium; other source
84305	23.62	Somatomedin
84307	23.62	Somatostatin
84311	9.03	Spectrophotometry, analyte not elsewhere specified
84315	3.50	Specific gravity (except urine)
84375	27.39	Sugars, chromatographic, TLC or paper chromatography
84376	7.69	Sugars (mono-, di-, and oligosaccharides); single qualitative, each specimen
84377	7.69	Sugars (mono-, di-, and oligosaccharides); multiple qualitative, each specimen
84378	16.10	Sugars (mono-, di-, and oligosaccharides); single quantitative, each specimen
84379	16.10	Sugars (mono-, di-, and oligosaccharides); multiple quantitative, each specimen
84392	6.64	Sulfate, urine
84402	35.57	Testosterone; free
84403	36.08	Testosterone; total
84425	29.67	Thiamine (Vitamin B-1)
84430	16.26	Thiocyanate
84432	22.44	Thyroglobulin
84436	9.61	Thyroxine; total
84437	9.04	Thyroxine; requiring elution (eg, neonatal)
84439	12.60	Thyroxine; free
84442	20.66	Thyroxine binding globulin (TBG)
84443	23.47	Thyroid stimulating hormone (TSH)
84445	71.05	Thyroid stimulating immune globulins (TSI)
84446	19.81	Tocopherol alpha (Vitamin E)
84449	24.57	Transcortin (cortisol binding globulin)
84450	7.22	Transferase; aspartate amino (AST) (SGOT)
84460	7.40	Transferase; alanine amino (ALT) (SGPT)
84460	7.40	Transferase; alanine amino (ALT) (SGPT)
84466	17.84	Transferrin
84478	8.04	Triglycerides
84478	8.04	Triglycerides
84479	9.04	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)
84480	19.81	Triiodothyronine T3; total (TT-3)
84481	23.67	Triiodothyronine T3; free
84482	21.27	Triiodothyronine T3; reverse
84484	13.75	Troponin, quantitative

Code	Fee	40.06(4) – Clinical Lab Description
84485	10.49	Trypsin; duodenal fluid
84488	9.61	Trypsin; feces, qualitative
84490	10.63	Trypsin; feces, quantitative, 24-hour collection
84510	14.53	Tyrosine
84512	10.31	Troponin, qualitative
84520	5.51	Urea nitrogen; quantitative
84525	5.25	Urea nitrogen; semiquantitative (eg, reagent strip test)
84540	6.64	Urea nitrogen, urine
84545	9.23	Urea nitrogen, clearance
84550	6.31	Uric acid; blood
84560	6.64	Uric acid; other source
84577	17.43	Urobilinogen, feces, quantitative
84578	4.54	Urobilinogen, urine; qualitative
84580	8.92	Urobilinogen, urine; quantitative, timed specimen
84583	7.02	Urobilinogen, urine; semiquantitative
84585	21.66	Vanillylmandelic acid (VMA), urine
84586	26.68	Vasoactive intestinal peptide (VIP)
84588	47.43	Vasopressin (antidiuretic hormone, ADH)
84590	16.20	Vitamin A
84591	16.20	Vitamin, not otherwise specified
84597	19.15	Vitamin K
84600	22.45	Volatiles (eg, acetic anhydride, carbon tetrachloride, dichloroethane, dichloromethane, diethylether, isopropyl alcohol, methanol)
84620	16.55	Xylose absorption test, blood and/or urine
84630	15.91	Zinc
84681	29.07	C-peptide
84702	21.03	Gonadotropin, chorionic (hCG); quantitative
84703	10.49	Gonadotropin, chorionic (hCG); qualitative
84703	10.49	Gonadotropin, chorionic (hCG); qualitative
84830	14.02	Ovulation tests, by visual color comparison methods for human luteinizing hormone
85002	6.29	Bleeding time
85004	9.04	Blood count; automated differential WBC count
85007	4.81	Blood count; blood smear, microscopic examination with manual differential WBC count
85008	4.81	Blood count; blood smear, microscopic examination without manual differential WBC count
85009	5.19	Blood count; manual differential WBC count, buffy coat
85013	3.31	Blood count; spun microhematocrit
85014	3.31	Blood count; hematocrit (Hct)
85014	3.31	Blood count; hematocrit (Hct)
85018	3.31	Blood count; hemoglobin (Hgb)
85018	3.31	Blood count; hemoglobin (Hgb)
85025	10.86	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	9.04	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85032	6.01	Blood count; manual cell count (erythrocyte, leukocyte, or platelet) each

Code	Fee	40.06(4) – Clinical Lab Description
85041	4.05	Blood count; red blood cell (RBC), automated
85044	6.01	Blood count; reticulocyte, manual
85045	5.59	Blood count; reticulocyte, automated
85046	7.80	Blood count; reticulocytes, hemoglobin concentration
85048	3.55	Blood count; leukocyte (WBC), automated
85049	6.25	Blood count; platelet, automated
85055	15.37	Reticulated platelet assay
85130	10.68	Chromogenic substrate assay
85170	5.05	Clot retraction
85175	5.41	Clot lysis time, whole blood dilution
85210	18.14	Clotting; factor II, prothrombin, specific
85220	24.66	Clotting; factor V (AcG or proaccelerin), labile factor
85230	25.02	Clotting; factor VII (proconvertin, stable factor)
85240	25.02	Clotting; factor VIII (AHG), one stage
85244	28.53	Clotting; factor VIII related antigen
85245	32.06	Clotting; factor VIII, VW factor, ristocetin cofactor
85246	32.06	Clotting; factor VIII, VW factor antigen
85247	32.06	Clotting; factor VIII, von Willebrand factor, multimetric analysis
85250	26.60	Clotting; factor IX (PTC or Christmas)
85260	25.02	Clotting; factor X (Stuart-Prower)
85270	25.02	Clotting; factor XI (PTA)
85280	27.04	Clotting; factor XII (Hageman)
85290	22.83	Clotting; factor XIII (fibrin stabilizing)
85291	12.42	Clotting; factor XIII (fibrin stabilizing), screen solubility
85292	26.46	Clotting; prekallikrein assay (Fletcher factor assay)
85293	26.46	Clotting; high molecular weight kininogen assay (Fitzgerald factor assay)
85300	16.55	Clotting inhibitors or anticoagulants; antithrombin III, activity
85301	15.11	Clotting inhibitors or anticoagulants; antithrombin III, antigen assay
85302	16.80	Clotting inhibitors or anticoagulants; protein C, antigen
85303	17.81	Clotting inhibitors or anticoagulants; protein C, activity
85305	16.20	Clotting inhibitors or anticoagulants; protein S, total
85306	19.97	Clotting inhibitors or anticoagulants; protein S, free
85307	19.97	Activated Protein C (APC) resistance assay
85335	17.99	Factor inhibitor test
85337	14.56	Thrombomodulin
85345	6.01	Coagulation time; Lee and White
85347	5.95	Coagulation time; activated
85348	5.20	Coagulation time; other methods
85360	11.74	Euglobulin lysis
85362	9.62	Fibrin(ogen) degradation (split) products (FDP)(FSP); agglutination slide, semiquantitative
85366	10.54	Fibrin(ogen) degradation (split) products (FDP)(FSP); paracoagulation
85370	9.60	Fibrin(ogen) degradation (split) products (FDP)(FSP); quantitative
85378	9.97	Fibrin degradation products, D-dimer; qualitative or semiquantitative
85379	14.22	Fibrin degradation products, D-dimer; quantitative

Code	Fee	40.06(4) – Clinical Lab Description
85380	14.22	Fibrin degradation products, D-dimer; ultrasensitive (eg, for evaluation for venous thromboembolism), qualitative or semiquantitative
85384	11.87	Fibrinogen; activity
85385	11.87	Fibrinogen; antigen
85390	7.22	Fibrinolysins or coagulopathy screen, interpretation and report
85400	12.36	Fibrinolytic factors and inhibitors; plasmin
85410	10.77	Fibrinolytic factors and inhibitors; alpha-2 antiplasmin
85415	24.02	Fibrinolytic factors and inhibitors; plasminogen activator
85420	9.13	Fibrinolytic factors and inhibitors; plasminogen, except antigenic assay
85421	14.23	Fibrinolytic factors and inhibitors; plasminogen, antigenic assay
85441	5.88	Heinz bodies; direct
85445	9.52	Heinz bodies; induced, acetyl phenylhydrazine
85460	8.11	Hemoglobin or RBCs, fetal, for fetomaternal hemorrhage; differential lysis (Kleihauer-Betke)
85461	9.26	Hemoglobin or RBCs, fetal, for fetomaternal hemorrhage; rosette
85475	12.40	Hemolysin, acid
85520	18.29	Heparin assay
85525	16.55	Heparin neutralization
85530	19.81	Heparin-protamine tolerance test
85536	9.04	Iron stain, peripheral blood
85540	12.02	Leukocyte alkaline phosphatase with count
85547	8.92	Mechanical fragility, RBC
85549	26.21	Muramidase
85555	9.34	Osmotic fragility, RBC; unincubated
85557	11.36	Osmotic fragility, RBC; incubated
85576	30.01	Platelet, aggregation (in vitro), each agent
85597	6.53	Platelet neutralization
85610	5.49	Prothrombin time;
85610	5.49	Prothrombin time;
85611	5.51	Prothrombin time; substitution, plasma fractions, each
85612	8.38	Russell viper venom time (includes venom); undiluted
85613	8.38	Russell viper venom time (includes venom); diluted
85635	13.76	Reptilase test
85651	4.96	Sedimentation rate, erythrocyte; non-automated
85652	3.77	Sedimentation rate, erythrocyte; automated
85660	7.71	Sickling of RBC, reduction
85670	8.07	Thrombin time; plasma
85675	9.58	Thrombin time; titer
85705	9.77	Thromboplastin inhibition; tissue
85730	8.38	Thromboplastin time, partial (PTT); plasma or whole blood
85732	9.04	Thromboplastin time, partial (PTT); substitution, plasma fractions, each
85810	16.32	Viscosity
86000	9.75	Agglutinins, febrile (eg, Brucella, Francisella, Murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus), each antigen
86001	7.30	Allergen specific IgG quantitative or semiquantitative, each allergen

Code	Fee	40.06(4) – Clinical Lab Description
86003	7.30	Allergen specific IgE; quantitative or semiquantitative, each allergen
86005	11.14	Allergen specific IgE; qualitative, multiallergen screen (dipstick, paddle or disk)
86021	21.03	Antibody identification; leukocyte antibodies
86022	25.66	Antibody identification; platelet antibodies
86023	17.40	Antibody identification; platelet associated immunoglobulin assay
86038	16.89	Antinuclear antibodies (ANA);
86039	15.60	Antinuclear antibodies (ANA); titer
86060	10.20	Antistreptolysin 0; titer
86063	8.07	Antistreptolysin 0; screen
86140	7.23	C-reactive protein;
86141	18.09	C-reactive protein; high sensitivity (hsCRP)
86146	19.21	Beta 2 Glycoprotein I antibody, each
86147	19.21	Cardiolipin (phospholipid) antibody, each Ig class
86148	19.21	Anti-phosphatidylserine (phospholipid) antibody
86155	22.33	Chemotaxis assay, specify method
86156	8.91	Cold agglutinin; screen
86157	11.27	Cold agglutinin; titer
86160	16.78	Complement; antigen, each component
86161	16.78	Complement; functional activity, each component
86162	28.39	Complement; total hemolytic (CH50)
86171	12.16	Complement fixation tests, each antigen
86185	12.50	Counterimmunoelectrophoresis, each antigen
86215	18.51	Deoxyribonuclease, antibody
86225	19.20	Deoxyribonucleic acid (DNA) antibody; native or double stranded
86226	16.92	Deoxyribonucleic acid (DNA) antibody; single stranded
86235	25.06	Extractable nuclear antigen, antibody to, any method (eg, nRNP, SS-A, SS-B, Sm, RNP, Sc170, J01), each antibody
86243	28.68	Fc receptor
86255	12.16	Fluorescent noninfectious agent antibody; screen, each antibody
86256	16.84	Fluorescent noninfectious agent antibody; titer, each antibody
86277	21.99	Growth hormone, human (HGH), antibody
86280	11.44	Hemagglutination inhibition test (HAI)
86294	27.41	Immunoassay for tumor antigen, qualitative or semiquantitative (eg, bladder tumor antigen)
86294	27.41	Immunoassay for tumor antigen, qualitative or semiquantitative (eg, bladder tumor antigen)
86300	29.07	Immunoassay for tumor antigen, quantitative; CA 15-3 (27.29)
86301	29.07	Immunoassay for tumor antigen, quantitative; CA 19-9
86304	29.07	Immunoassay for tumor antigen, quantitative; CA 125
86308	7.23	Heterophile antibodies; screening
86308	7.23	Heterophile antibodies; screening
86309	9.04	Heterophile antibodies; titer
86310	10.30	Heterophile antibodies; titers after absorption with beef cells and guinea pig kidney
86316	29.07	Immunoassay for tumor antigen; other antigen, quantitative (eg, CA 50, 72-4, 549), each
86317	20.95	Immunoassay for infectious agent antibody, quantitative, not otherwise specified
86318	18.09	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg,

Code	Fee	40.06(4) – Clinical Lab Description
		reagent strip)
86318	18.09	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg, reagent strip)
86320	31.32	Immunoelectrophoresis; serum
86325	31.24	Immunoelectrophoresis; other fluids (eg, urine, cerebrospinal fluid) with concentration
86327	31.70	Immunoelectrophoresis; crossed (2-dimensional assay)
86329	19.62	Immunodiffusion; not elsewhere specified
86331	16.75	Immunodiffusion; gel diffusion, qualitative (Ouchterlony), each antigen or antibody
86332	34.05	Immune complex assay
86334	31.21	Immunofixation electrophoresis
86336	21.77	Inhibin A
86337	29.92	Insulin antibodies
86340	21.06	Intrinsic factor antibodies
86341	27.65	Islet cell antibody
86343	17.41	Leukocyte histamine release test (LHR)
86344	11.16	Leukocyte phagocytosis
86353	68.49	Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis
86359	16.01	T cells; total count
86360	19.21	T cells; absolute CD4 and CD8 count, including ratio
86361	15.37	T cells; absolute CD4 count
86376	20.33	Microsomal antibodies (eg, thyroid or liver-kidney), each
86378	27.51	Migration inhibitory factor test (MIF)
86382	23.62	Neutralization test, viral
86384	15.91	Nitroblue tetrazolium dye test (NTD)
86403	14.24	Particle agglutination; screen, each antibody
86406	14.87	Particle agglutination; titer, each antibody
86430	7.93	Rheumatoid factor; qualitative
86431	7.93	Rheumatoid factor; quantitative
86590	15.41	Streptokinase, antibody
86592	5.96	Syphilis test; qualitative (eg, VDRL, RPR, ART)
86593	6.16	Syphilis test; quantitative
86602	13.64	Antibody; actinomyces
86603	14.58	Antibody; adenovirus
86606	20.59	Antibody; Aspergillus
86609	13.64	Antibody; bacterium, not elsewhere specified
86611	13.64	Antibody; Bartonella
86612	18.03	Antibody; Blastomyces
86615	18.43	Antibody; Bordetella
86617	21.64	Antibody; Borrelia burgdorferi (Lyme disease) confirmatory test (eg, Western Blot or immunoblot)
86618	19.97	Antibody; Borrelia burgdorferi (Lyme disease)
86618	19.97	Antibody; Borrelia burgdorferi (Lyme disease)
86619	18.69	Antibody; Borrelia (relapsing fever)
86622	12.14	Antibody; Brucella
86625	13.64	Antibody; Campylobacter

Code	Fee	40.06(4) – Clinical Lab Description
86628	16.78	Antibody; Candida
86631	16.52	Antibody; Chlamydia
86632	17.74	Antibody; Chlamydia, IgM
86635	16.03	Antibody; Coccidioides
86638	16.94	Antibody; Coxiella burnetii (Q fever)
86641	12.14	Antibody; Cryptococcus
86644	20.11	Antibody; cytomegalovirus (CMV)
86645	19.97	Antibody; cytomegalovirus (CMV), IgM
86648	13.64	Antibody; Diphtheria
86651	18.43	Antibody; encephalitis, California (La Crosse)
86652	18.43	Antibody; encephalitis, Eastern equine
86653	18.43	Antibody; encephalitis, St. Louis
86654	18.43	Antibody; encephalitis, Western equine
86658	14.58	Antibody; enterovirus (eg, coxsackie, echo, polio)
86663	18.33	Antibody; Epstein-Barr (EB) virus, early antigen (EA)
86664	19.97	Antibody; Epstein-Barr (EB) virus, nuclear antigen (EBNA)
86665	19.97	Antibody; Epstein-Barr (EB) virus, viral capsid (VCA)
86666	13.64	Antibody; Ehrlichia
86668	12.14	Antibody; Francisella tularensis
86671	13.64	Antibody; fungus, not elsewhere specified
86674	19.97	Antibody; Giardia lamblia
86677	20.28	Antibody; Helicobacter pylori
86682	13.64	Antibody; helminth, not elsewhere specified
86684	13.64	Antibody; Haemophilus influenza
86687	11.72	Antibody; HTLV-I
86688	13.94	Antibody; HTLV-II
86689	27.05	Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot)
86692	23.62	Antibody; hepatitis, delta agent
86694	20.11	Antibody; herpes simplex, non-specific type test
86695	18.43	Antibody; herpes simplex, type 1
86696	27.05	Antibody; herpes simplex, type 2
86698	17.46	Antibody; histoplasma
86701	12.41	Antibody; HIV-1
86701	12.41	Antibody; HIV-1
86702	14.75	Antibody; HIV-2
86703	14.75	Antibody; HIV-1 and HIV-2, single assay
86704	16.84	Hepatitis B core antibody (HBcAb); total
86705	16.44	Hepatitis B core antibody (HBcAb); IgM antibody
86706	14.61	Hepatitis B surface antibody (HBsAb)
86707	16.16	Hepatitis Be antibody (HBeAb)
86708	16.24	Hepatitis A antibody (HAAb); total
86709	15.73	Hepatitis A antibody (HAAb); IgM antibody
86710	14.58	Antibody; influenza virus
86713	21.39	Antibody; Legionella

Code	Fee	40.06(4) – Clinical Lab Description
86717	13.00	Antibody; Leishmania
86720	12.14	Antibody; Leptospira
86723	13.00	Antibody; Listeria monocytogenes
86727	14.58	Antibody; lymphocytic choriomeningitis
86729	16.69	Antibody; lymphogranuloma venereum
86732	13.00	Antibody; mucormycosis
86735	18.23	Antibody; mumps
86738	14.58	Antibody; mycoplasma
86741	13.00	Antibody; Neisseria meningitidis
86744	13.00	Antibody; Nocardia
86747	13.00	Antibody; parvovirus
86750	13.00	Antibody; Plasmodium (malaria)
86753	13.00	Antibody; protozoa, not elsewhere specified
86756	18.01	Antibody; respiratory syncytial virus
86757	27.05	Antibody; Rickettsia
86759	18.43	Antibody; rotavirus
86762	20.11	Antibody; rubella
86765	18.00	Antibody; rubeola
86768	13.00	Antibody; Salmonella
86771	13.00	Antibody; Shigella
86774	13.00	Antibody; tetanus
86777	20.11	Antibody; Toxoplasma
86778	20.12	Antibody; Toxoplasma, IgM
86781	18.50	Antibody; Treponema pallidum, confirmatory test (eg, FTA-abs)
86784	17.55	Antibody; Trichinella
86787	18.00	Antibody; varicella-zoster
86790	13.00	Antibody; virus, not elsewhere specified
86793	13.00	Antibody; Yersinia
86800	20.70	Thyroglobulin antibody
86803	16.24	Hepatitis C antibody;
86804	21.64	Hepatitis C antibody; confirmatory test (eg, immunoblot)
86805	73.05	Lymphocytotoxicity assay, visual crossmatch; with titration
86806	66.49	Lymphocytotoxicity assay, visual crossmatch; without titration
86807	55.29	Serum screening for cytotoxic percent reactive antibody (PRA); standard method
86808	41.47	Serum screening for cytotoxic percent reactive antibody (PRA); quick method
86812	36.06	HLA typing; A, B, or C (eg, A10, B7, B27), single antigen
86813	81.02	HLA typing; A, B, or C, multiple antigens
86816	38.92	HLA typing; DR/DQ, single antigen
86817	89.95	HLA typing; DR/DQ, multiple antigens
86821	78.88	HLA typing; lymphocyte culture, mixed (MLC)
86822	51.07	HLA typing; lymphocyte culture, primed (PLC)
86880	7.50	Antihuman globulin test (Coombs test); direct, each antiserum
86885	7.99	Antihuman globulin test (Coombs test); indirect, qualitative, each antiserum
86886	7.23	Antihuman globulin test (Coombs test); indirect, titer, each antiserum

Code	Fee	40.06(4) – Clinical Lab Description
86900	4.17	Blood typing; ABO
86903	13.19	Blood typing; antigen screening for compatible blood unit using reagent serum, per unit screened
86904	13.28	Blood typing; antigen screening for compatible unit using patient serum, per unit screened
86905	5.34	Blood typing; RBC antigens, other than ABO or Rh (D), each
86906	10.83	Blood typing; Rh phenotyping, complete
86940	11.46	Hemolysins and agglutinins; auto, screen, each
86941	16.92	Hemolysins and agglutinins; incubated
87001	6.88	Animal inoculation, small animal; with observation
87003	23.52	Animal inoculation, small animal; with observation and dissection
87015	9.33	Concentration (any type), for infectious agents
87040	14.42	Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)
87045	13.18	Culture, bacterial; stool, aerobic, with isolation and preliminary examination (eg, KIA, LIA), Salmonella and Shigella species
87046	13.18	Culture, bacterial; stool, aerobic, additional pathogens, isolation and presumptive identification of isolates
87070	12.03	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates
87071	13.18	Culture, bacterial; quantitative, aerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool
87073	13.18	Culture, bacterial; quantitative, anaerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool
87075	13.22	Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates
87076	7.30	Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate
87077	7.30	Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate
87077	7.30	Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate
87081	9.26	Culture, presumptive, pathogenic organisms, screening only;
87084	9.75	Culture, presumptive, pathogenic organisms, screening only; with colony estimation from density chart
87086	11.28	Culture, bacterial; quantitative colony count, urine
87088	11.31	Culture, bacterial; with isolation and presumptive identification of isolates, urine
87101	10.77	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail
87102	11.74	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; other source (except blood)
87103	12.60	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; blood
87106	14.42	Culture, fungi, definitive identification, each organism; yeast
87107	14.42	Culture, fungi, definitive identification, each organism; mold
87109	21.50	Culture, mycoplasma, any source
87110	27.37	Culture, chlamydia, any source
87116	15.10	Culture, tubercle or other acid-fast bacilli (eg, TB, AFB, mycobacteria) any source, with isolation and presumptive identification of isolates
87118	15.29	Culture, mycobacterial, definitive identification, each isolate
87140	7.79	Culture, typing; immunofluorescent method, each antiserum
87143	17.51	Culture, typing; gas liquid chromatography (GLC) or high pressure liquid chromatography (HPLC) method
87147	7.23	Culture, typing; immunologic method, other than immunofluoresence (eg, agglutination grouping), per antiserum

Code	Fee	40.06(4) – Clinical Lab Description
87149	28.02	Culture, typing; identification by nucleic acid probe
87152	7.31	Culture, typing; identification by pulse field gel typing
87158	7.31	Culture, typing; other methods
87164	8.11	Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection
87166	8.11	Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection
87168	5.96	Macroscopic examination; arthropod
87169	5.96	Macroscopic examination; parasite
87172	5.96	Pinworm exam (eg, cellophane tape prep)
87176	8.22	Homogenization, tissue, for culture
87177	12.43	Ova and parasites, direct smears, concentration and identification
87181	6.64	Susceptibility studies, antimicrobial agent; agar dilution method, per agent (eg, antibiotic gradient strip)
87184	9.63	Susceptibility studies, antimicrobial agent; disk method, per plate (12 or fewer agents)
87185	6.64	Susceptibility studies, antimicrobial agent; enzyme detection (eg, beta lactamase), per enzyme
87186	12.08	Susceptibility studies, antimicrobial agent; microdilution or agar dilution (minimum inhibitory concentration (MIC) or breakpoint), each multi-antimicrobial, per plate
87187	14.48	Susceptibility studies, antimicrobial agent; microdilution or agar dilution, minimum lethal concentration (MLC), each plate (List separately in addition to code for primary procedure)
87188	9.27	Susceptibility studies, antimicrobial agent; macrobroth dilution method, each agent
87190	6.88	Susceptibility studies, antimicrobial agent; mycobacteria, proportion method, each agent
87197	20.99	Serum bactericidal titer (Schlicter test)
87205	5.96	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
87206	7.50	Smear, primary source with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types
87207	8.37	Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses
87210	5.96	Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)
87210	5.96	Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)
87220	5.96	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies)
87230	27.30	Toxin or antitoxin assay, tissue culture (eg, Clostridium difficile toxin)
87250	27.32	Virus isolation; inoculation of embryonated eggs, or small animal, includes observation and dissection
87252	36.42	Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect
87253	28.22	Virus isolation; tissue culture, additional studies or definitive identification (eg, hemabsorption, neutralization, immunofluoresence stain), each isolate
87254	27.32	Virus isolation; centrifuge enhanced (shell vial) technique, includes identification with immunofluorescence stain, each virus
87255	47.31	Virus isolation; including identification by non-immunologic method, other than by cytopathic effect (eg, virus specific enzymatic activity)
87260	16.01	Infectious agent antigen detection by immunofluorescent technique; adenovirus
87265	16.01	Infectious agent antigen detection by immunofluorescent technique; Bordetella pertussis/parapertussis
87267	16.01	Infectious agent antigen detection by immunofluorescent technique; Enterovirus, direct fluorescent antibody (DFA)
87269	16.01	Infectious agent antigen detection by immunofluorescent technique; giardia

Code	Fee	40.06(4) – Clinical Lab Description
87270	16.01	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis
87271	16.01	Infectious agent antigen detection by immunofluorescent technique; Cytomegalovirus, direct fluorescent antibody (DFA)
87272	16.01	Infectious agent antigen detection by immunofluorescent technique; cryptosporidium
87273	16.01	Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 2
87274	16.01	Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 1
87275	16.01	Infectious agent antigen detection by immunofluorescent technique; influenza B virus
87276	16.01	Infectious agent antigen detection by immunofluorescent technique; influenza A virus
87277	16.01	Infectious agent antigen detection by immunofluorescent technique; Legionella micdadei
87278	16.01	Infectious agent antigen detection by immunofluorescent technique; Legionella pneumophila
87279	16.01	Infectious agent antigen detection by immunofluorescent technique; Parainfluenza virus, each type
87280	16.01	Infectious agent antigen detection by immunofluorescent technique; respiratory syncytial virus
87281	16.01	Infectious agent antigen detection by immunofluorescent technique; Pneumocystis carinii
87283	16.01	Infectious agent antigen detection by immunofluorescent technique; Rubeola
87285	16.01	Infectious agent antigen detection by immunofluorescent technique; Treponema pallidum
87290	16.01	Infectious agent antigen detection by immunofluorescent technique; Varicella zoster virus
87299	16.01	Infectious agent antigen detection by immunofluorescent technique; not otherwise specified, each organism
87300	16.01	Infectious agent antigen detection by immunofluorescent technique, polyvalent for multiple organisms, each polyvalent antiserum
87301	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; adenovirus enteric types 40/41
87320	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Chlamydia trachomatis
87324	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Clostridium difficile toxin(s)
87327	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Cryptococcus neoformans
87328	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; cryptosporidium
87329	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; giardia
87332	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; cytomegalovirus
87335	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Escherichia coli 0157
87336	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Entamoeba histolytica dispar group
87337	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Entamoeba histolytica group
87338	16.04	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Helicobacter pylori, stool
87339	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Helicobacter pylori
87340	14.43	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; hepatitis B surface antigen (HBsAg)
87341	14.43	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative,

Code	Fee	40.06(4) – Clinical Lab Description
		multiple step method; hepatitis B surface antigen (HBsAg) neutralization
87350	16.10	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; hepatitis Be antigen (HBeAg)
87380	15.54	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; hepatitis, delta agent
87385	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Histoplasma capsulatum
87390	24.65	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-1
87391	24.65	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-2
87400	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Influenza, A or B, each
87420	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; respiratory syncytial virus
87425	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; rotavirus
87427	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Shiga-like toxin
87430	16.01	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Streptococcus, group A
87449	16.01	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism
87449	16.01	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism
87450	10.68	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; single step method, not otherwise specified, each organism
87451	10.68	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, polyvalent for multiple organisms, each polyvalent antiserum
87470	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, direct probe technique
87471	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, amplified probe technique
87472	59.85	Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, quantification
87475	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Borrelia burgdorferi, direct probe technique
87476	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Borrelia burgdorferi, amplified probe technique
87477	59.85	Infectious agent detection by nucleic acid (DNA or RNA); Borrelia burgdorferi, quantification
87480	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique
87481	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique
87482	58.33	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, quantification
87485	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, direct probe technique
87486	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, amplified probe technique
87487	59.85	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, quantification
87490	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique

Code	Fee	40.06(4) – Clinical Lab Description
87491	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
87492	22.93	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification
87495	28.02	Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, direct probe technique
87496	36.39	Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, amplified probe technique
87497	59.85	Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, quantification
87510	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, direct probe technique
87511	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, amplified probe technique
87512	58.33	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, quantification
87515	28.02	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, direct probe technique
87516	36.39	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, amplified probe technique
87517	59.85	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, quantification
87520	28.02	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, direct probe technique
87521	36.39	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, amplified probe technique
87522	59.85	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, quantification
87525	28.02	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, direct probe technique
87526	36.39	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, amplified probe technique
87527	58.33	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, quantification
87528	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, direct probe technique
87529	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, amplified probe technique
87530	59.85	Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, quantification
87531	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, direct probe technique
87532	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, amplified probe technique
87533	58.33	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, quantification
87534	28.02	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique
87535	36.39	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique
87536	78.52	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification
87537	28.02	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique
87538	36.39	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique
87539	59.85	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, quantification
87540	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, direct probe technique
87541	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, amplified probe technique
87542	58.33	Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, quantification
87550	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, direct probe technique
87551	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, amplified probe technique
87552	59.85	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, quantification
87555	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, direct probe technique
87556	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, amplified probe technique

Code	Fee	40.06(4) – Clinical Lab Description
87557	59.85	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, quantification
87560	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, direct probe technique
87561	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, amplified probe technique
87562	59.85	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, quantification
87580	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, direct probe technique
87581	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, amplified probe technique
87582	58.33	Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, quantification
87590	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique
87591	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
87592	59.85	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification
87620	28.02	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, direct probe technique
87621	36.39	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique
87622	58.33	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, quantification
87650	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, direct probe technique
87651	36.39	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique
87652	58.33	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, quantification
87660	28.02	Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique
87797	28.02	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism
87798	36.39	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism
87799	59.85	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism
87800	56.03	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique
87801	72.78	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique
87802	16.01	Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group B
87803	16.01	Infectious agent antigen detection by immunoassay with direct optical observation; Clostridium difficile toxin A
87804	16.01	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza
87804	16.01	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza
87810	16.01	Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis
87850	16.01	Infectious agent detection by immunoassay with direct optical observation; Neisseria gonorrhoeae
87880	16.01	Infectious agent detection by immunoassay with direct optical observation; Streptococcus, group A
87880	16.01	Infectious agent detection by immunoassay with direct optical observation; Streptococcus, group A
87899	16.01	Infectious agent detection by immunoassay with direct optical observation; not otherwise specified
87899	16.01	Infectious agent detection by immunoassay with direct optical observation; not otherwise specified

Code	Fee	40.06(4) – Clinical Lab Description
87901	114.95	Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV 1, reverse transcriptase and protease
87902	114.95	Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis C virus
87903	682.72	Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1; first through 10 drugs tested
87904	36.42	Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1; each additional 1 through 5 drugs tested (List separately in addition to code for primary procedure)
88130	21.02	Sex chromatin identification; Barr bodies
88140	11.17	Sex chromatin identification; peripheral blood smear, polymorphonuclear drumsticks
88142	28.31	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88143	28.31	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision
88147	15.90	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88148	21.23	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision
88150	14.76	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88152	14.76	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision
88153	14.76	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
88154	14.76	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88155	8.37	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code(s) for other technical and interpretation services)
88164	14.76	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165	14.76	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision
88166	14.76	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision
88167	14.76	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88174	29.85	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
88175	37.01	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening, under physician supervision
88230	48.38	Tissue culture for non-neoplastic disorders; lymphocyte
88233	122.81	Tissue culture for non-neoplastic disorders; skin or other solid tissue biopsy
88235	122.81	Tissue culture for non-neoplastic disorders; amniotic fluid or chorionic villus cells
88237	55.83	Tissue culture for neoplastic disorders; bone marrow, blood cells
88239	206.12	Tissue culture for neoplastic disorders; solid tumor
88240	14.11	Cryopreservation, freezing and storage of cells, each cell line
88241	14.11	Thawing and expansion of frozen cells, each aliquot
88245	207.98	Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE), 20-25 cells

Code	Fee	40.06(4) – Clinical Lab Description
88248	241.96	Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (eg, for ataxia telangiectasia, Fanconi anemia, fragile X)
88249	241.96	Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (eg, diepoxybutane, mitomycin C, ionizing radiation, UV radiation)
88261	246.93	Chromosome analysis; count 5 cells, 1 karyotype, with banding
88262	174.14	Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding
88263	204.68	Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding
88264	174.14	Chromosome analysis; analyze 20-25 cells
88267	251.17	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding
88269	232.38	Chromosome analysis, in situ for amniotic fluid cells, count cells from 6-12 colonies, 1 karyotype, with banding
88271	29.93	Molecular cytogenetics; DNA probe, each (eg, FISH)
88272	37.41	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (eg, for derivatives and markers)
88273	44.89	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (eg, for microdeletions)
88274	48.63	Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells
88275	56.11	Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells
88280	35.07	Chromosome analysis; additional karyotypes, each study
88283	95.84	Chromosome analysis; additional specialized banding technique (eg, NOR, C-banding)
88285	26.54	Chromosome analysis; additional cells counted, each study
88289	48.11	Chromosome analysis; additional high resolution study
88371	31.05	Protein analysis of tissue by Western Blot, with interpretation and report;
88372	31.79	Protein analysis of tissue by Western Blot, with interpretation and report; immunological probe for band identification, each
88400	7.02	Bilirubin, total, transcutaneous
89050	6.61	Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood;
89051	7.70	Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood; with differential count
89055	5.96	Leukocyte assessment, fecal, qualitative or semiquantitative
89060	9.99	Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)
89125	6.03	Fat stain, feces, urine, or respiratory secretions
89160	5.15	Meat fibers, feces
89190	6.64	Nasal smear for eosinophils
89225	4.67	Starch granules, feces
89235	7.69	Water load test
89300	9.77	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
89300	9.77	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
89310	12.03	Semen analysis; motility and count (not including Huhner test)
89320	16.84	Semen analysis; complete (volume, count, motility, and differential)
89321	16.84	Semen analysis, presence and/or motility of sperm
89325	14.91	Sperm antibodies
89329	29.30	Sperm evaluation; hamster penetration test
89330	13.83	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test
ATP02	7.28	Auto Test Panel (1-2)

Code	Fee	40.06(4) – Clinical Lab Description
ATP03	9.29	Auto Test Panel (3)
ATP04	9.80	Auto Test Panel (4)
ATP05	10.93	Auto Test Panel (5)
ATP06	10.96	Auto Test Panel (6)
ATP07	11.42	Auto Test Panel (7)
ATP08	11.83	Auto Test Panel (8)
ATP09	12.13	Auto Test Panel (9)
ATP10	12.13	Auto Test Panel (10)
ATP11	12.34	Auto Test Panel (11)
ATP12	12.62	Auto Test Panel (12)
ATP16	14.77	Auto Test Panel (13-16)
ATP18	14.87	Auto Test Panel (17-18)
ATP19	15.45	Auto Test Panel (19)
ATP20	15.95	Auto Test Panel (20)
ATP21	16.45	Auto Test Panel (21)
ATP22	16.95	Auto Test Panel (22)
G0001	3.00	Routine venipuncture for collection of specimen(s)
G0027	9.09	Semen analysis; presence and/or motility of sperm excluding huhner
G0103	25.70	Prostate cancer screening; prostate specific antigen test (PSA), total
G0107	4.54	Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations
G0123	28.31	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision
G0143	28.31	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision
G0144	29.85	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision
G0145	37.01	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision
G0147	15.90	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision
G0148	21.23	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening
G0265	14.11	Cryopreservation, freezing and storage of cells for therapeutic use, each cell line
G0266	14.11	Thawing and expansion of frozen cells for therapeutic use, each aliquot
G0306	10.86	Complete CBC, automated (HgB, HCT, RBC, WBC, without platelet count) and automated WBC differential count
G0307	9.04	Complete CBC, automated (HgB, HCT, RBC, WBC; without platelet count)
G0328	18.09	Colorectalcancer screening; fecal-occult blood test, immunoassay, 1-3 simultaneous determinations.
G0328	18.09	Colorectalcancer screening; fecal-occult blood test, immunoassay, 1-3 simultaneous determinations.
P2038	7.02	Mucoprotein, blood (seromucoid) (medical necessity procedure)
P3000	14.76	Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision
P9612	3.00	Catheterization for collection of specimen, single patient, all places of service
P9615	3.00	Catheterization for collection of specimen(s) (multiple patients)

Code	Fee	40.06(4) – Clinical Lab Description
Q0111	5.96	Wet mounts, including preparations of vaginal, cervical or skin specimens
Q0112	5.96	All potassium hydroxide (KOH) preparations
Q0113	7.56	Pinworm examination
Q0114	9.99	Fern test
Q0115	13.83	Post-coital direct, qualitative examinations of vaginal or cervical mucous

40.06(5) Dentists

Code	Fee	40.06(5) – Dental Service Description
99080	24.85	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. (An additional report that is completed at the request of the patient's employer, insurer, utilization reviewer or agent subsequent to the completion of the required report under 452 CMR 1.13(1). This fee is for the treating provider's preparation time only. (per 15 minutes)) (Do not report 99080 in conjunction with codes using modifier -32 or with 99455, 99456 for the completion of Workmen's Compensation forms)
99371	24.85	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (eg, to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or gent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 15 minutes.)
99372	49.70	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); intermediate (eg, to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or gent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 30 minutes.)
99373	74.55	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); complex or lengthy (eg, lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or gent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 45 minutes.)

Code	Fee	40.06(5) – Dental Service Description
D0120	22.25	periodic oral examination
D0130	45.32	periodic oral examination
D0140	45.32	limited oral exam- problem focused
D0150	42.85	comprehensive oral evaluation
D0160	69.34	detailed and extensive oral evaluation- problem focused
D0170	41.20	detailed and extensive oral evaluation- problem focused
D0210	79.10	intraoral - complete series (including bitewings)
D0211	98.06	intraoral - complete series (including bitewings)
D0220	16.48	intraoral - periapical - first film
D0230	14.01	intraoral - periapical - each additional film
D0240	23.07	intraoral-occlusal film
D0250	19.78	extraoral-first film
D0260	9.89	extraoral-each additional film
D0270	15.66	bitewing - single film
D0272	24.72	bitewings - two films

Code	Fee	40.06(5) – Dental Service Description
D0273	31.31	bitewings - two films
D0274	37.90	bitewings - four films
D0275	28.84	bitewings - four films
D0277	50.26	bitewings - four films
D0290	45.32	Posterior-anterior or lateral skull and facial bone survey film
D0310	89.73	Sialography
D0321	110.13	Other temporomandibular joint films, by report.
D0330	71.69	panoramic film
D0340	84.84	Cephalometric film
D0460	33.78	Pulp vitality tests
D0470	65.92	diagnostic casts
D0472	78.28	diagnostic casts
D0480	57.68	diagnostic casts
D1110	56.86	prophylaxis - adult
D1115	71.69	prophylaxis - adult
D1120	41.20	prophylaxis - child
D1124	78.28	prophylaxis - child
D1125	49.44	prophylaxis - child
D1201	57.68	topical application of fluoride (including prophylaxis) - child
D1203	21.42	topical application of fluoride (excluding prophylaxis) - child
D1204	21.42	topical application of fluoride (excluding prophylaxis) - adult
D1205	56.86	topical application of fluoride(including prophylaxis) - adult
D1351	32.96	sealant - per tooth
D1510	206.00	space maintainer - fixed unilateral
D1515	329.60	space maintainer - fixed bilateral
D1520	389.93	space maintainer - removable unilateral
D1525	370.80	space maintainer - removable bilateral
D1550	48.94	recementation of space maintainer
D2110	61.80	amalgam - one surface, primary
D2120	74.98	amalgam - two surfaces, primary
D2130	90.64	amalgam - three surfaces, primary
D2131	123.60	amalgam - four or more surfaces, primary
D2140	65.92	amalgam - one surface, permanent
D2150	82.40	amalgam - two surfaces, permanent
D2160	98.88	amalgam - three surfaces, permanent
D2161	123.60	amalgam - four or more surfaces, permanent
D2330	78.28	resin - one surface, anterior
D2331	98.88	resin - two surfaces, anterior
D2332	123.60	resin - three surfaces, anterior
D2335	156.56	resin - four or more surfaces or involving incisal angle (anterior)
D2336	261.04	composite resin crown, anterior primary
D2337	279.34	composite resin crown, anterior primary
D2380	79.93	resin-one surface-posterior-primary
D2381	103.00	Resin-two surfaces, posterior-primary

Code	Fee	40.06(5) – Dental Service Description
D2382	123.60	Resin-two surfaces, posterior-primary
D2385	88.17	Resin-one surface, posterior-permanent
D2386	123.60	Resin-two surfaces, posterior-permanent
D2387	151.62	resin-three or more surfaces posterior-permanent
D2388	163.15	resin-three or more surfaces posterior-permanent
D2530	329.60	inlay-metallic-two surfaces
D2540	675.68	inlay-metallic-two surfaces
D2542	536.42	inlay-metallic-two surfaces
D2543	741.60	Onlay-metallic three surfaces
D2544	768.79	Onlay-metallic four or more surfaces
D2620	453.20	inlay-porcelain/ceramic-two surfaces
D2630	688.04	inlay-porcelain/ceramic-three or more surfaces
D2640	762.20	inlay-porcelain/ceramic-three or more surfaces
D2642	725.12	onlay-porcelain/ceramic-two surfaces
D2643	700.40	onlay-porcelain/ceramic-three surfaces
D2644	708.64	onlay-porcelain/ceramic-four or more surfaces
D2660	506.76	onlay-porcelain/ceramic-four or more surfaces
D2662	713.80	onlay-composite/resin-two surfaces (laboratory processed)
D2663	657.55	onlay-composite/resin-three surfaces (laboratory processed)
D2664	657.55	onlay-composite/resin-four or more surfaces (laboratory processed)
D2710	247.20	crown - resin (laboratory)
D2720	679.80	crown - resin with high noble metal
D2721	734.19	crown-resin with predominately base metal
D2722	587.35	crown-resin with high noble metal
D2740	782.80	crown - porcelain/ceramic substrate
D2750	736.66	crown-procelain fused to high noble metal
D2751	659.20	crown-procelain fused to predominately base metal
D2752	679.80	crown-procelain fused to noble metal
D2780	758.08	crown-procelain fused to noble metal
D2783	733.36	crown-procelain fused to noble metal
D2790	741.60	crown-full cast high noble metal
D2791	632.22	crown-full cast predominately base metal
D2792	700.40	crown-full cast noble metal
D2799	206.00	crown-full cast noble metal
D2810	782.80	crown - _ cast metallic
D2910	61.80	recement inlay
D2920	61.80	recement crown
D2930	164.80	prefabricated stainless steel crown - primary tooth
D2931	182.93	prefabricated stainless steel crown - permanent tooth
D2932	226.60	prefabricated resin crown
D2940	65.10	Sedative filling
D2950	177.16	Core buildup, including any pins
D2951	28.84	pin retention-per tooth, in addition to restoration
D2952	249.26	Cast post and core in addition to restoration

Code	Fee	40.06(5) – Dental Service Description
D2954	206.00	prefabricated post and core in addition to crown
D2961	453.20	Labial veneer (resin laminate-laboratory)
D2962	618.00	Labial veneer (porcelain laminate-laboratory)
D2970	164.80	Temporary (fractured tooth)
D2980	123.60	Crown repair, by report
D3110	37.08	Pulp cap-direct (excluding final restoration)
D3120	37.08	Pulp cap-indirect (excluding final restoration)
D3220	94.76	therapeutic pulpotomy (excluding final restoration)
D3221	123.60	therapeutic pulpotomy (excluding final restoration)
D3310	432.60	anterior (excluding final restoration)
D3320	506.76	bicuspid (excluding final restoration)
D3330	656.73	molar (excluding final restoration)
D3332	206.00	molar (excluding final restoration)
D3333	247.20	molar (excluding final restoration)
D3346	490.28	Retreatment of previous root canal therapy-anterior
D3347	576.80	Retreatment of previous root canal therapy-bicuspid
D3348	659.20	Retreatment of previous root canal therapy-molar
D3351	134.60	Apexification/precalcification-initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3410	436.72	apicoectomy/periradicular surgery-anterior
D3421	494.40	apicoectomy/periradicular surgery - bicuspid (first root)
D3425	642.72	Apicoectomy/periradicular surgery molar (first root)
D3426	247.20	Apicoectomy/periradicular surgery (each additional root)
D3430	82.40	Retrograde filling-per root
D3450	309.00	Root amputation-per root
D3920	226.60	Hemissection (including any root removal), not including root canal therapy
D4210	329.60	gingivectomy or gingivopl-per quadrant
D4211	119.48	gingivectomy or gingivopl-per tooth
D4220	122.37	Gingival curettage, surgical, per quadrant, by report
D4240	482.04	Gingival flap procedure, including root planing-per quadrant
D4249	494.40	Clinical crown lengthening-hard tissue
D4250	737.48	Clinical crown lengthening-hard tissue
D4260	700.40	Osseous surgery(including flap entry and closure)-per quadrant
D4261	762.20	Osseous surgery(including flap entry and closure)-per quadrant
D4263	206.00	Bone replacement graft-first site in quadrant
D4264	326.31	Bone replacement graft-each additional site in quadrant
D4266	329.60	Guided tissue regeneration-resorbable barrier, per site per tooth
D4267	329.60	Guided tissue regeneration-non-resorbable barrier, per site per tooth (includes membrane removal)
D4270	649.31	Pedicle soft tissue graft procedure
D4271	597.40	Free soft tissue graft procedure (including donor site surgery)
D4273	700.40	Subepithelial connective tissue graft procedure (including donor site surgery)
D4274	350.20	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)
D4340	114.54	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the

Code	Fee	40.06(5) – Dental Service Description
		same anatomical area)
D4341	144.20	Periodontal scaling and root planing-per quadrant
D4345	74.16	Periodontal scaling and root planing-per quadrant
D4355	83.22	Full mouth debidement to enable comprehensive periodontal evaluation and diagnosis
D4381	77.49	Localized deliver of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report
D4910	75.81	Periodontal maintenance procedures (following active therapy)
D5110	782.80	complete denture-maxillary
D5120	782.80	complete denture-mandibular
D5130	824.00	immediate denture-maxillary
D5140	823.18	immediate denture-mandibular
D5211	597.40	maxillary partial-resin base (including any conventional clasps, rests and teeth)
D5212	638.60	manibular partial-resin base (including any conventional clasps, rests, and teeth)
D5213	803.40	maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214	813.29	mandibular partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5281	453.20	Removable unilateral partial denture-one piece cast metal (including clasps and teeth)
D5410	45.32	adjust complete denture-maxillary
D5411	45.32	adjust complete denture-mandibular
D5421	56.03	adjust partial denture-maxillary
D5422	41.20	adjust partial denture-mandibular
D5510	86.52	repair broken complete denture base
D5520	82.40	replace missing or broken teeth - complete denture (each tooth)
D5610	82.40	repair resin denture base
D5620	103.00	repair cast framework
D5630	107.12	Repair or replace broken clasp
D5640	82.40	replace broken teeth - per tooth
D5650	98.88	add tooth to existing partial denture
D5660	103.00	add clasp to existing partial denture
D5710	271.92	rebase complete maxillary denture
D5711	224.34	rebase complete mandibular denture
D5720	247.20	rebase maxillary partial denture
D5721	306.53	rebase mandibular partial denture
D5730	168.92	reline complete maxillary denture (chairside)
D5731	185.40	reline lower complete mandibular denture (chairside)
D5740	152.44	reline maxillary partial denture (chairside)
D5741	144.20	reline mandibular partial denture (chairside)
D5750	229.90	reline complete maxillary denture (laboratory)
D5751	230.72	reline complete mandibular denture (laboratory)
D5760	226.60	reline maxillary partial denture (laboratory)
D5761	226.60	reline mandibular partial denture (laboratory)
D5820	288.40	interim partial denture (maxillary)
D5821	317.24	interim partial denture (mandibular)

Code	Fee	40.06(5) – Dental Service Description
D5850	77.46	tissue conditioning, maxillary
D5851	70.04	tissue conditioning, mandibular
D5862	247.20	Precision attachment, by report
D6010	1,236.00	surgical placement of implant body: endosteal implant
D6020	403.80	abutment placement or substitution: endosteal implant
D6030	1,429.64	abutment placement or substitution: endosteal implant
D6040	1,648.00	surgical placement: eposteal implant
D6050	1,223.66	surgical placement: transosteal implant
D6055	571.04	dental implant-supported connecting bar
D6056	298.29	dental implant-supported connecting bar
D6057	432.60	dental implant-supported connecting bar
D6058	988.80	dental implant-supported connecting bar
D6059	811.64	dental implant-supported connecting bar
D6060	782.80	dental implant-supported connecting bar
D6061	814.94	dental implant-supported connecting bar
D6062	824.00	dental implant-supported connecting bar
D6064	988.80	dental implant-supported connecting bar
D6065	988.80	dental implant-supported connecting bar
D6066	943.48	dental implant-supported connecting bar
D6067	1,071.20	dental implant-supported connecting bar
D6080	103.00	implant maintenance procedures, including:removal of prosthesis, cleansing of prosthesis and abutmen reinsertion of prosthesis
D6210	700.40	pontic - cast high noble metal
D6211	652.62	pontic - cast predominantly base metal
D6212	678.98	pontic - cast noble metal
D6240	721.00	pontic - porcelain fused to high noble metal
D6241	650.96	pontic - porcelain fused to predominantly base metal
D6242	659.20	pontic - porcelain fused to noble metal
D6250	700.40	pontic - resin with high noble metal
D6251	648.53	pontic - resin with predominantly base metal
D6252	611.83	pontic - resin with noble metal
D6520	489.46	inlay - metallic - two surfaces
D6530	701.56	inlay - metallic - three or more surfaces
D6540	692.16	inlay - metallic - three or more surfaces
D6543	614.28	onlay - metallic - three surfaces
D6544	655.08	onlay - metallic - four or more surfaces
D6545	288.40	retainer-cast metal for resin bonded fixed prosthesis
D6720	571.04	crown - resin with high noble metal
D6721	938.14	crown - resin with predominantly base metal
D6722	222.48	crown - resin with predominantly base metal
D6750	725.12	crown - porcelain fused to high noble metal
D6751	655.08	crown - porcelain fused to predominantly base metal
D6752	659.20	crown - porcelain fused to noble metal
D6780	689.32	crown - 3/4 cast high noble metal

Code	Fee	40.06(5) – Dental Service Description
D6790	700.40	crown - full cast high noble metal
D6791	611.83	crown - full cast predominantly base metal
D6792	634.48	crown - full cast noble metal
D6930	78.28	recement bridge
D6970	412.00	cast post and core in addition to bridge retainer
D6971	301.02	cast post as part of bridge retainer
D6972	183.55	prefabricated post and core in addition to bridge retainer
D6973	144.20	core build up for retainer, including any pins
D6980	144.20	bridge repair, by report
D7110	82.40	single tooth
D7120	78.28	each additional tooth
D7130	103.00	root removal - exposed roots
D7210	160.68	surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	206.00	removal of impacted tooth - soft tissue
D7230	267.80	removal of impacted tooth - partially bony
D7240	317.24	removal of impacted tooth - completely bony
D7241	350.20	removal of impacted tooth - completely bony, with unusual surgical complications
D7250	159.07	surgical removal of residual tooth roots (cutting procedure)
D7260	247.20	oral antral fistula closure
D7280	448.67	surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)
D7281	329.60	surgical exposure of impacted or unerupted tooth to aid eruption
D7285	244.73	biopsy of oral tissue - hard
D7286	177.16	biopsy of oral tissue - soft
D7291	147.50	transseptal fiberotomy, by report
D7310	152.44	alveoloplasty in conjunction with extractions - per quadrant
D7320	201.88	alveoloplasty not in conjunction with extractions - per quadrant
D7340	803.40	alveoloplasty not in conjunction with extractions - per quadrant
D7350	494.40	vestibuloplasty - ridge extension (including soft tissue grafts, muscle re attachments, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue)
D7410	244.73	radical excision - lesion diameter up to 1.25 cm
D7430	188.44	excision of benign tumor - lesion diameter up to 1.25 cm
D7431	206.00	excision of benign tumor - lesion diameter up to 1.25 cm
D7450	226.60	removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	309.00	removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7460	142.76	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7465	163.15	destruction of lesion(s) by physical or chemical methods, by report
D7470	391.40	removal of exostosis - maxilla or mandible
D7480	183.55	partial ostectomy (guttering or saucerization)
D7510	103.00	incision and drainage of abscess - intraoral soft tissue
D7520	86.52	incision and drainage of abscess - extraoral soft tissue
D7530	226.60	removal of foreign body, skin, or subcutaneous areolar tissue
D7540	195.79	removal of reaction producing foreign bodies - musculoskeletal system

Code	Fee	40.06(5) – Dental Service Description
D7670	123.60	removal of reaction producing foreign bodies - musculoskeletal system
D7780	123.60	removal of reaction producing foreign bodies - musculoskeletal system
D7880	370.80	occlusal orthotic appliance
D7881	321.36	occlusal orthotic appliance
D7911	26.92	complicated suture-up to 5 cm.
D7960	317.24	frenulectomy (frenectomy or frenotomy) - separate procedure
D9110	61.80	palliative (emergency) treatment of dental pain - minor procedures
D9220	187.05	general anesthesia
D9221	103.00	general anesthesia - each additional 15 minutes
D9230	34.61	analgesia
D9241	206.00	analgesia
D9242	82.40	analgesia
D9310	57.68	consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
D9910	24.48	application of desensitizing medicaments
D9940	276.04	occlusal guards, by report
D9952	160.68	occlusal adjustment - complete

40.06(6) Durable Medical Equipment, Prosthetics/Orthotics, and Supplies

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
A4214	1.49			Sterile saline or water, 30 cc vial
A4216	0.45			Sterile water/saline, 10 ml
A4217	2.66			Sterile water/saline, 500 ml
A4221	22.64			Supplies for maintenance of drug infusion catheter, per week (list drug separately)
A4222	46.73			Supplies for external drug infusion pump, per cassette or bag (list drug separately)
A4253	38.52			Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4254	6.58	4.94	0.67	Replacement battery, any type, for use with medically necessary home blood glucose monitor owned by patient, each
A4255	3.91			Platforms for home blood glucose monitor, 50 per box
A4256	11.44			Normal, low, and high calibrator solution/chips
A4257	12.75			Replacement lens shield cartridge for use with laser skin piercing device, each
A4258	18.05			Spring-powered device for lancet, each
A4259	10.83			Lancets, per box of 100
A4265	3.39			Paraffin, per pound
A4280	5.09			Adhesive skin support attachment for use with external breast prosthesis, each
A4290	104.86			Sacral nerve stimulation test lead, each
A4310	7.72			Insertion tray without drainage bag and without catheter (accessories only)
A4311	13.97			Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)
A4312	15.33			Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone
A4313	15.74			Insertion tray without drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation
A4314	21.50			Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)
A4315	22.43			Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone
A4316	28.40			Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation
A4319	6.33			Sterile water irrigation solution, 1000 ml
A4320	5.33			Irrigation tray with bulb or piston syringe, any purpose
A4321	I.C.			Therapeutic agent for urinary catheter irrigation
A4322	3.04			Irrigation syringe, bulb or piston, each
A4323	7.46			Sterile saline irrigation solution, 1000 ml
A4324	2.17			Male external catheter, with adhesive coating, each
A4325	1.80			Male external catheter, with adhesive strip, each
A4326	10.37			Male external catheter specialty type with integral collection chamber, each
A4327	42.27			Female external urinary collection device; metal cup, each

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
A4328	8.88			Female external urinary collection device; pouch, each
A4330	7.15			Perianal fecal collection pouch with adhesive, each
A4331	3.18			Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each
A4332	0.12			Lubricant, individual sterile packet, for insertion of urinary catheter, each
A4333	2.20			Urinary catheter anchoring device, adhesive skin attachment, each
A4334	4.93			Urinary catheter anchoring device, leg strap, each
A4338	12.26			Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each
A4340	31.75			Indwelling catheter; specialty type, (e.g., coude, mushroom, wing, etc.), each
A4344	15.20			Indwelling catheter, Foley type, two-way, all silicone, each
A4346	19.59			Indwelling catheter; Foley type, three-way for continuous irrigation, each
A4347	20.35			Male external catheter with or without adhesive, with or without anti-reflux device; per dozen
A4348	27.83			Male external catheter with integral collection compartment, extended wear, each (e.g., 2 per month)
A4351	1.81			Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each
A4352	6.42			Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each
A4353	6.99			Intermittent urinary catheter, with insertion supplies
A4354	11.80			Insertion tray with drainage bag but without catheter
A4355	7.57			Irrigation tubing set for continuous bladder irrigation through a three-way indwelling Foley catheter, each
A4356	38.79			External urethral clamp or compression device (not to be used for catheter clamp), each
A4357	8.25			Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each
A4358	6.63			Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each
A4359	27.21			Urinary suspensory without leg bag, each
A4361	17.83			Ostomy faceplate, each
A4362	2.94			Skin barrier; solid, four by four or equivalent; each
A4364	2.89			Adhesive, liquid, or equal, any type, per ounce
A4365	11.32			Adhesive remover wipes, any type, per 50
A4366	1.30			Ostomy vent, any type, each
A4367	6.62			Ostomy belt, each
A4368	0.26			Ostomy filter, any type, each
A4369	2.42			Ostomy skin barrier, liquid (spray, brush, etc), per oz
A4371	3.65			Ostomy skin barrier, powder, per oz
A4372	4.18			Ostomy skin barrier, solid 4x4 or equivalent, with built-in convexity, each
A4373	6.28			Ostomy skin barrier, with flange (solid, flexible or accordion), with built-in convexity, any

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
				size, each
A4375	17.18			Ostomy pouch, drainable, with faceplate attached, plastic, each
A4376	47.58			Ostomy pouch, drainable, with faceplate attached, rubber, each
A4377	4.29			Ostomy pouch, drainable, for use on faceplate, plastic, each
A4378	30.75			Ostomy pouch, drainable, for use on faceplate, rubber, each
A4379	15.02			Ostomy pouch, urinary, with faceplate attached, plastic, each
A4380	37.33			Ostomy pouch, urinary, with faceplate attached, rubber, each
A4381	4.61			Ostomy pouch, urinary, for use on faceplate, plastic, each
A4382	24.62			Ostomy pouch, urinary, for use on faceplate, heavy plastic, each
A4383	28.19			Ostomy pouch, urinary, for use on faceplate, rubber, each
A4384	9.62			Ostomy faceplate equivalent, silicone ring, each
A4385	5.10			Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each
A4387	I.C.			Ostomy pouch, closed, with barrier attached, with built-in convexity (one piece), each
A4388	4.36			Ostomy pouch, drainable, with extended wear barrier attached, (one piece), each
A4389	6.22			Ostomy pouch, drainable, with barrier attached, with built-in convexity (one piece), each
A4390	9.61			Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each
A4391	7.07			Ostomy pouch, urinary, with extended wear barrier attached (1 piece), each
A4392	8.18			Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each
A4393	9.04			Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each
A4394	2.58			Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce
A4395	0.05			Ostomy deodorant for use in ostomy pouch, solid, per tablet
A4396	40.48			Ostomy belt with peristomal hernia support
A4397	4.07			Irrigation supply; sleeve, each
A4398	13.56			Ostomy irrigation supply; bag, each
A4399	12.26			Ostomy irrigation supply; cone/catheter, including brush
A4400	48.87			Ostomy irrigation set
A4402	1.36			Lubricant, per ounce
A4404	1.69			Ostomy ring, each
A4405	3.40			Ostomy skin barrier, non-pectin based, paste, per ounce
A4406	5.74			Ostomy skin barrier, pectin-based, paste, per ounce
A4407	8.76			Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each
A4408	9.87			Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each
A4409	6.22			Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
A4410	9.04			Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each
A4413	5.50			Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each
A4414	4.93			Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each
A4415	6.00			Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4x4 inches, each
A4416	2.75			Ostomy pouch, closed, with barrier attached, with filter (one piece), each
A4417	3.72			Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (one piece), each
A4418	1.81			Ostomy pouch, closed; without barrier attached, with filter (one piece), each
A4419	1.74			Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (two piece), each
A4420	I.C.			Ostomy pouch, closed; for use on barrier with locking flange (two piece), each
A4422	0.12			Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each
A4423	1.86			Ostomy pouch, closed; for use on barrier with locking flange, with filter (two piece), each
A4424	4.75			Ostomy pouch, drainable, with barrier attached, with filter (one piece), each
A4425	3.58			Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (two piece system), each
A4426	2.73			Ostomy pouch, drainable; for use on barrier with locking flange (two piece system), each
A4427	2.78			Ostomy pouch, drainable; for use on barrier with locking flange, with filter (two piece system), each
A4428	6.51			Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (one piece), each
A4429	8.25			Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each
A4430	8.52			Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each
A4431	6.22			Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (one piece), each
A4432	3.59			Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (two piece), each
A4433	3.34			Ostomy pouch, urinary; for use on barrier with locking flange (two piece), each
A4434	3.76			Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (two piece), each
A4450	0.09			Tape, non-waterproof, per 18 square inches
A4450	0.09			Tape, non-waterproof, per 18 square inches
A4450	0.11			Tape, non-waterproof, per 18 square inches
A4452	0.36			Tape, waterproof, per 18 square inches
A4452	0.40			Tape, waterproof, per 18 square inches
A4452	0.36			Tape, waterproof, per 18 square inches

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
A4455	1.43			Adhesive remover or solvent (for tape, cement or other adhesive), per ounce
A4462	3.29			Abdominal dressing holder, each
A4481	0.37			Tracheostoma filter, any type, any size, each
A4483	I.C.			Moisture exchanger, disposable, for use with invasive mechanical ventilation
A4556	10.32			Electrodes (e.g., Apnea monitor), per pair
A4557	21.10			Lead wires (e.g., Apnea monitor), per pair
A4558	4.63			Conductive paste or gel
A4561	18.63			Pessary, rubber, any type
A4562	46.38			Pessary, non rubber, any type
A4595	28.81			Electrical stimulator supplies, 2 lead, per month, (e.g. tens, nmes)
A4608	58.15			Transtracheal oxygen catheter, each
A4609	14.30			Tracheal suction catheter, closed system, for less than 72 hours of use, each
A4610	22.34			Tracheal suction catheter, closed system, for 72 or more hours of use, each
A4611	196.45	147.34	20.37	Battery, heavy duty; replacement for patient-owned ventilator
A4612	79.93	60.95	8.14	Battery cables; replacement for patient-owned ventilator
A4613	122.58	88.65	12.27	Battery charger; replacement for patient-owned ventilator
A4614	23.78			Peak expiratory flow rate meter, hand held
A4618	8.89	6.67	1.02	Breathing circuits
A4619	1.21			Face tent
A4621	1.39			Tracheostomy mask or collar
A4622	57.27			Tracheostomy or laryngectomy tube
A4623	6.55			Tracheostomy, inner cannula
A4624	2.24			Tracheal suction catheter, any type other than closed system, each
A4625	5.89			Tracheostomy care kit for new tracheostomy
A4626	3.19			Tracheostomy cleaning brush, each
A4628	3.74			Oropharyngeal suction catheter, each
A4629	4.63			Tracheostomy care kit for established tracheostomy
A4630	6.25			Replacement batteries for medically necessary transcutaneous electrical nerve stimulator (TENS) owned by patient
A4631	101.10	75.07	10.31	Replacement batteries for medically necessary electronic wheelchair owned by patient
A4633	41.04			Replacement bulb/lamp for ultraviolet light therapy system, each
A4635	5.12	3.39	0.69	Underarm pad, crutch, replacement, each
A4636	4.21	3.07	0.43	Replacement, handgrip, cane, crutch, or walker, each
A4637	2.13	1.61	0.30	Replacement, tip, cane, crutch, walker, each
A4638	I.C.	I.C.	I.C.	Replacement battery for patient-owned ear pulse generator, each
A4639	287.21			Replacement pad for infrared heating pad system, each
A4640	63.32	44.86	6.45	Replacement pad for use with medically necessary alternating pressure pad owned by patient

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
A4649	I.C.			Surgical supply, miscellaneous
A4913	I.C.			Miscellaneous dialysis supplies, not otherwise specified
A5051	2.07			Ostomy pouch, closed; with barrier attached (one piece), each
A5052	1.49			Ostomy pouch, closed; without barrier attached (one piece), each
A5053	1.49			Ostomy pouch, closed; for use on faceplate, each
A5054	1.79			Ostomy pouch, closed; for use on barrier with flange (two piece), each
A5055	1.44			Stoma cap
A5061	3.52			Ostomy pouch, drainable; with barrier attached, (one piece), each
A5062	2.22			Ostomy pouch, drainable; without barrier attached (one piece), each
A5063	2.70			Ostomy pouch, drainable; for use on barrier with flange (two piece system), each
A5071	6.01			Ostomy pouch, urinary; with barrier attached (one piece), each
A5072	3.52			Ostomy pouch, urinary; without barrier attached (one piece), each
A5073	3.18			Ostomy pouch, urinary; for use on barrier with flange (two piece), each
A5081	3.30			Continent device; plug for continent stoma
A5082	11.89			Continent device; catheter for continent stoma
A5093	1.95			Ostomy accessory; convex insert
A5102	22.42			Bedside drainage bottle, with or without tubing, rigid or expandable, each
A5105	34.65			Urinary suspensory; with leg bag, with or without tube
A5112	29.93			Urinary leg bag; latex
A5113	4.47			Leg strap; latex, replacement only, per set
A5114	7.60			Leg strap; foam or fabric, replacement only, per set
A5119	10.85			Skin barrier; wipes, box per 50
A5121	7.39			Skin barrier; solid, 6 x 6 or equivalent, each
A5122	10.92			Skin barrier; solid, 8 x 8 or equivalent, each
A5126	1.32			Adhesive or non-adhesive; disk or foam pad
A5131	15.86			Appliance cleaner, incontinence and ostomy appliances, per 16 oz.
A5200	11.30			Percutaneous catheter/tube anchoring device, adhesive skin attachment
A6010	30.96			Collagen based wound filler, dry form, per gram of collagen
A6011	2.28			Collagen based wound filler, gel/paste, per gram of collagen
A6021	21.02			Collagen dressing, pad size 16 sq. in. or less, each
A6022	21.02			Collagen dressing, pad size more than 16 sq. in. but less than or equal to 48 sq in, each
A6023	190.30			Collagen dressing, pad size more than 48 sq. in., each
A6024	6.19			Collagen dressing wound filler, per 6 in
A6154	14.38			Wound pouch, each
A6196	7.35			Alginate or other fiber gelling dressing, wound cover, pad size 16 sq in or less, each dressing
A6197	16.44			Alginate or other fiber gelling dressing, wound cover, pad size more than 16 sq in but less

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
				than or equal to 48 sq in, each dressing
A6199	5.29			Alginate or other fiber gelling dressing, wound filler, per 6 inches
A6200	9.50			Composite dressing, pad size 16 sq. in. or less, without adhesive border, each dressing
A6201	20.80			Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6202	34.88			Composite dressing, pad size more than 48 sq. in., without adhesive border, each dressing
A6203	3.35			Composite dressing, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6204	6.23			Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6207	7.34			Contact layer, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing
A6209	7.48			Foam dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing
A6210	19.92			Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6211	29.37			Foam dressing, wound cover, pad size more then 48 sq. in., without adhesive border, each dressing
A6212	9.70			Foam dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6214	10.29			Foam dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing
A6216	0.05			Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
A6217	I.C.			Gauze, non-impregnated, non-sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6219	0.95			Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6220	2.58			Gauze, non-impregnated, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6222	2.13			Gauze, impregnated with other than water, normal saline, or hydrogel, pad size 16 sq. in. or less, without adhesive border, each dressing
A6223	2.42			Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6224	3.61			Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 48 sq. in., without adhesive border, each dressing
A6229	3.61			Gauze, impregnated, water or normal saline, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6231	4.66			Gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. in. or less, each dressing
A6232	6.88			Gauze, impregnated, hydrogel, for direct wound contact, pad size greater than 16 sq. in., but less than or equal to 48 sq. in., each dressing
A6233	19.19			Gauze, impregnated, hydrogel for direct wound contact, pad size more than 48 sq. in., each dressing
A6234	6.54			Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
A6235	16.82			Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6236	27.25			Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing
A6237	7.91			Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6238	22.79			Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6240	12.24			Hydrocolloid dressing, wound filler, paste, per fluid ounce
A6241	2.57			Hydrocolloid dressing, wound filler, dry form, per gram
A6242	6.07			Hydrogel dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing
A6243	12.31			Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6244	39.28			Hydrogel dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing
A6245	7.27			Hydrogel dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6246	9.92			Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6247	23.78			Hydrogel dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing
A6248	16.24			Hydrogel dressing, wound filler, gel, per fluid ounce
A6251	1.99			Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing
A6252	3.25			Specialty absorptive dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6253	6.34			Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing
A6254	1.21			Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6255	3.03			Specialty absorptive dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6257	1.53			Transparent film, 16 sq. in. or less, each dressing
A6258	4.30			Transparent film, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing
A6259	10.94			Transparent film, more than 48 sq. in., each dressing
A6266	1.92			Gauze, impregnated, other than water, normal saline, or zinc paste, any width, per linear yard
A6402	0.12			Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
A6403	0.43			Gauze, non-impregnated, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6407	1.88			Packing strips, non-impregnated, up to two inches in width, per linear yard
A6410	0.39			Eye pad, sterile, each

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
A6411	I.C.			Eye pad, non-sterile, each
A6421	2.09			Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per roll (at least three yards, unstretched)
A6422	1.17			Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches per roll (at least three yards, unstretched)
A6424	2.05			Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to five inches, per roll (at least three yards, unstretched)
A6426	1.88			Conforming bandage, non-elastic, knitted/woven, sterile width greater than or equal to three inches and less than five inches, per roll (at least three yards, unstretched)
A6428	3.04			Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per roll (at least three yards, unstretched)
A6430	8.76			Light compression bandage, elastic, knitted/woven, load resistance less than 1.25 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per roll (at least three yards, unstretched)
A6432	I.C.			Light compression bandage, elastic, knitted/woven, load resistance less than 1.25 foot pounds at 50% maximum stretch, width greater than or equal to five inches, per roll (at least three yards, unstretched)
A6434	I.C.			Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three inches or less than five inches, per roll (at least three yards, unstretched)
A6436	19.08			High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per roll (at least three yards, unstretched)
A6438	I.C.			Self-adherent bandage, elastic, non-knitted/non-woven, load resistance greater than or equal to 0.55 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per roll (at least three yards, unstretched)
A6440	12.69			Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per roll (at least 10 yards, unstretched)
A6441	0.67			Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard
A6442	0.17			Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard
A6443	0.29			Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard
A6444	0.56			Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to five inches, per yard
A6445	0.32			Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard
A6446	0.41			Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard
A6447	0.67			Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard
A6448	1.16			Light compression bandage, elastic, knitted/woven, width less than three inches, per yard
A6449	1.75			Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard
A6450	I.C.			Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
A6451	I.C.			Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50 percent maximum stretch, width greater than or equal to three inches and less than five inches, per yard
A6452	5.91			High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50 percent maximum stretch, width greater than or equal to three inches and less than five inches, per yard
A6453	0.61			Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard
A6454	0.77			Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard
A6455	1.39			Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard
A6456	1.28			Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard
A6501	I.C.			Compression burn garment, bodysuit (head to foot), custom fabricated
A6502	I.C.			Compression burn garment, chin strap, custom fabricated
A6503	I.C.			Compression burn garment, facial hood, custom fabricated
A6504	I.C.			Compression burn garment, glove to wrist, custom fabricated
A6505	I.C.			Compression burn garment, glove to elbow, custom fabricated
A6506	I.C.			Compression burn garment, glove to axilla, custom fabricated
A6507	I.C.			Compression burn garment, foot to knee length, custom fabricated
A6508	I.C.			Compression burn garment, foot to thigh length, custom fabricated
A6509	I.C.			Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated
A6510	I.C.			Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated
A6511	I.C.			Compression burn garment, lower trunk including leg openings (panty), custom fabricated
A6550	27.42			Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each
A6551	24.53			Canister set for negative pressure wound therapy electrical pump, stationary or portable, each
A7000	8.75			Canister, disposable, used with suction pump, each
A7001	31.30			Canister, non-disposable, used with suction pump, each
A7002	3.63			Tubing, used with suction pump, each
A7003	2.74			Administration set, with small volume nonfiltered pneumatic nebulizer, disposable
A7004	1.55			Small volume nonfiltered pneumatic nebulizer, disposable
A7005	29.20			Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable
A7006	8.54			Administration set, with small volume filtered pneumatic nebulizer
A7007	4.18			Large volume nebulizer, disposable, unfilled, used with aerosol compressor
A7008	11.00			Large volume nebulizer, disposable, prefilled, used with aerosol compressor
A7009	39.79			Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
A7010	23.59			Corrugated tubing, disposable, used with large volume nebulizer, 100 feet
A7012	3.76			Water collection device, used with large volume nebulizer
A7013	0.78			Filter, disposable, used with aerosol compressor
A7014	4.24			Filter, non-disposable, used with aerosol compressor or ultrasonic generator
A7015	1.72			Aerosol mask, used with DME nebulizer
A7016	6.85			Dome and mouthpiece, used with small volume ultrasonic nebulizer
A7017	134.04	100.52	13.40	Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen
A7018	0.38			Water, distilled, used with large volume nebulizer, 1000 ml
A7019	0.34			Saline solution, per 10 ml, metered dose dispenser, for use with inhalation drugs
A7020	2.75			Sterile water or sterile saline, 1000 ml, used with large volume nebulizer
A7025	434.94			High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each
A7026	28.75			High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each
A7030	188.64			Full face mask used with positive airway pressure device, each
A7031	69.77			Face mask interface, replacement for full face mask, each
A7032	40.53			Replacement cushion for nasal application device, each
A7033	28.41			Replacement pillows for nasal application device, pair
A7034	117.64			Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap
A7035	37.16			Headgear used with positive airway pressure device
A7036	18.20			Chinstrap used with positive airway pressure device
A7037	41.02			Tubing used with positive airway pressure device
A7038	4.58			Filter, disposable, used with positive airway pressure device
A7039	15.33			Filter, non disposable, used with positive airway pressure device
A7042	165.63			Implanted pleural catheter, each
A7043	23.50			Vacuum drainage bottle and tubing for use with implanted catheter
A7044	120.91			Oral interface used with positive airway pressure device, each
A7046	19.51			Water chamber for humidifier, used with positive airway pressure device, replacement, each
A7501	105.03			Tracheostoma valve, including diaphragm, each
A7502	49.91			Replacement diaphragm/faceplate for tracheostoma valve, each
A7503	11.33			Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each
A7504	0.67			Filter for use in a tracheostoma heat and moisture exchange system, each
A7505	4.68			Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each
A7506	0.33			Adhesive disc for use in a heat and moisture exchange system and/or with tracheostoma valve, any type each
A7507	2.49			Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
				moisture exchange system, each
A7508	2.87			Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each
A7509	1.41			Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each
A7520	47.48			Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each
A7521	47.05			Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each
A7522	45.16			Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each
A7524	77.40			Tracheostoma stent/stud/button, each
A7525	2.07			Tracheostomy mask, each
A7526	3.37			Tracheostomy tube collar/holder, each
A9900	I.C.	I.C.	I.C.	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code
A9901	I.C.			DME delivery, set up, and/or dispensing service component of another HCPCS code
A9990	I.C.	I.C.	I.C.	Miscellaneous DME supply or accessory, not otherwise specified
B4034	5.78			Enteral feeding supply kit; syringe, per day
B4035	11.02			Enteral feeding supply kit; pump fed, per day
B4036	7.55			Enteral feeding supply kit; gravity fed, per day
B4081	20.42			Nasogastric tubing with stylet
B4082	15.20			Nasogastric tubing without stylet
B4083	2.32			Stomach tube - Levine type
B4086	33.71			Gastrostomy/jejunostomy tube, any material, any type, (standard or low profile), each
B4150	0.63			Enteral formulae; category I; semi-synthetic intact protein/protein isolates, administered through an enteral feeding tube, 100 calories = 1 unit
B4151	1.48			Enteral formulae; category I: natural intact protein/protein isolates, administered through an enteral feeding tube, 100 calories = 1 unit
B4152	0.53			Enteral formulae; category II: intact protein/protein isolates (calorically dense), administered through an enteral feeding tube, 100 calories = 1 unit
B4153	1.80			Enteral formulae; category III: hydrolyzed protein/amino acids, administered through an enteral feeding tube, 100 calories = 1 unit
B4154	1.15			Enteral formulae; category IV: defined formula for special metabolic need, administered through an enteral feeding tube, 100 calories = 1 unit
B4155	0.90			Enteral formulae; category V: modular components, administered through an enteral feeding tube, 100 calories = 1 unit
B4156	1.28			Enteral formulae; category VI: standardized nutrients, administered through an enteral feeding tube, 100 calories = 1 unit
B4164	15.57			Parenteral nutrition solution; carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - home mix
B4168	22.67			Parenteral nutrition solution; amino acid, 3.5%, (500 ml = 1 unit) - home mix
B4176	43.88			Parenteral nutrition solution; amino acid, 7% through 8.5%, (500 ml = 1 unit) - home mix
B4178	52.68			Parenteral nutrition solution; amino acid, greater than 8.5% (500 ml = 1 unit) - home mix
B4180	22.31			Parenteral nutrition solution; carbohydrates (dextrose), greater than 50% (500 ml = 1 unit)

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
				- home mix
B4184	73.14			Parenteral nutrition solution; lipids, 10% with administration set (500 ml = 1 unit)
B4186	97.53			Parenteral nutrition solution; lipids, 20% with administration set (500 ml = 1 unit)
B4189	162.74			Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein - premix
B4193	210.30			Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein - premix
B4197	256.02			Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, 74 to 100 grams of protein - premix
B4199	292.56			Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein - premix
B4216	7.08			Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) - home mix, per day
B4220	7.33			Parenteral nutrition supply kit; premix, per day
B4222	9.04			Parenteral nutrition supply kit; home mix, per day
B4224	22.90			Parenteral nutrition administration kit, per day
B5000	10.88			Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal - amirosyn RF, nephramine, renamine - premix
B5100	4.26			Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic - freamine HBC, hepatamine - premix
B9000	1,158.13	868.60	106.42	Enteral nutrition infusion pump - without alarm
B9002	1,158.13	868.60	112.17	Enteral nutrition infusion pump - with alarm
B9004	2,310.15	1,732.61	365.72	Parenteral nutrition infusion pump, portable
B9006	2,310.15	1,732.61	365.72	Parenteral nutrition infusion pump, stationary
B9998	I.C.			NOC for enteral supplies
B9999	I.C.			NOC for parenteral supplies
E0100	20.29	15.20	5.31	Cane, includes canes of all materials, adjustable or fixed, with tip
E0105	48.46	36.35	7.53	Cane, quad or three-prong, includes canes of all materials, adjustable or fixed, with tips
E0110	77.59	58.18	15.99	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips
E0111	53.26	41.10	8.43	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip
E0112	31.45	24.00	8.44	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips
E0113	21.13	15.86	5.15	Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip
E0114	40.11	30.32	7.28	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips
E0116	27.74	20.88	4.59	Crutch, underarm, other than wood, adjustable or fixed, each, with pad, tip and handgrip
E0117	192.71	144.55	19.26	Crutch, underarm, articulating, spring assisted, each

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
E0130	64.70	48.52	14.30	Walker, rigid (pickup), adjustable or fixed height
E0135	83.84	64.32	14.67	Walker, folding (pickup), adjustable or fixed height
E0140	360.71	270.54	36.08	Walker, with trunk support, adjustable or fixed height, any type
E0141	114.09	85.57	19.01	Walker, rigid, wheeled, adjustable or fixed height
E0142	171.98	130.98	26.43	Rigid walker, wheeled, with seat
E0143	120.23	89.98	18.35	Walker, folding, wheeled, adjustable or fixed height
E0144	318.45	203.01	27.08	Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat
E0147	574.81	431.13	57.48	Walker, heavy duty, multiple braking system, variable wheel resistance
E0148	127.05	95.28	12.72	Walker, heavy duty, without wheels, rigid or folding, any type, each
E0149	223.20	167.39	22.32	Walker, heavy duty, wheeled, rigid or folding, any type
E0153	58.97	44.23	6.66	Platform attachment, forearm crutch, each
E0154	65.40	49.06	7.28	Platform attachment, walker, each
E0155	31.56	24.05	3.85	Wheel attachment, rigid pick-up walker, per pair seat attachment, walker
E0156	26.43	19.85	3.38	Seat attachment, walker
E0157	81.92	61.45	8.99	Crutch attachment, walker, each
E0158	32.18	24.12	3.55	Leg extensions for walker, per set of four (4)
E0159	17.81	13.38	1.80	Brake attachment for wheeled walker, replacement, each
E0160	33.06	24.77	3.96	Sitz type bath or equipment, portable, used with or without commode
E0161	22.30	16.69	3.57	Sitz type bath or equipment, portable, used with or without commode, with faucet attachment(s)
E0162	145.70	113.00	15.29	Sitz bath chair
E0163	102.25	76.67	20.77	Commode chair, stationary, with fixed arms
E0164	181.40	136.05	26.43	Commode chair, mobile, with fixed arms
E0167	12.00	9.04	1.07	Pail or pan for use with commode chair
E0168	150.92	113.18	15.17	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each
E0175	64.98	48.74	6.51	Foot rest, for use with commode chair, each
E0176	91.04	67.68	12.03	Air pressure pad or cushion, nonpositioning
E0177	90.22	67.68	10.33	Water pressure pad or cushion, nonpositioning
E0178	103.14	77.35	12.76	Gel or gel-like pressure pad or cushion, nonpositioning
E0179	10.17	8.00	1.05	Dry pressure pad or cushion, nonpositioning
E0184	194.70	149.32	23.78	Dry pressure mattress
E0185	319.86	245.48	44.94	Gel or gel-like pressure pad for mattress, standard mattress length and width
E0188	22.47	16.87	2.64	Synthetic sheepskin pad
E0189	51.96	38.98	5.31	Lambswool sheepskin pad, any size
E0191	9.99	7.46	1.02	Heel or elbow protector, each
E0192	387.01	290.26	38.70	Low pressure and positioning equalization pad, for wheelchair
E0197	188.34	165.44	25.98	Air pressure pad for mattress, standard mattress length and width
E0198	188.34	142.92	19.51	Water pressure pad for mattress, standard mattress length and width
E0199	28.30	21.21	2.82	Dry pressure pad for mattress, standard mattress length and width
E0200	67.39	50.57	9.15	Heat lamp, without stand (table model), includes bulb, or infrared element
E0205	164.95	123.71	18.14	Heat lamp, with stand, includes bulb, or infrared element

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
E0210	32.64	24.48	2.66	Electric heat pad, standard
E0215	60.21	45.17	6.30	Electric heat pad, moist
E0217	496.47	372.32	55.28	Water circulating heat pad with pump
E0220	7.20	5.38	0.76	Hot water bottle
E0221	2,113.46	1,585.10	211.34	Infrared heating pad system
E0225	330.35	247.76	32.56	Hydrocollator unit, includes pads
E0230	7.21	5.39	0.81	Ice cap or collar
E0238	22.98	16.90	2.61	Nonelectric heat pad, moist
E0239	449.83	337.39	44.99	Hydrocollator unit, portable
E0249	99.60	74.70	10.95	Pad for water circulating heat unit
E0271	222.04	173.46	23.06	Mattress, inner spring
E0272	202.37	151.05	21.13	Mattress, foam rubber
E0275	14.57	10.94	1.46	Bed pan, standard, metal or plastic
E0276	11.31	8.94	1.51	Bed pan, fracture, metal or plastic
E0280	36.58	27.42	3.65	Bed cradle, any type
E0300	2,838.62	2,128.96	283.86	Pediatric crib, hospital grade, fully enclosed
E0310	185.02	138.77	22.76	Bedside rails, full-length
E0315	I.C.	I.C.	I.C.	Bed accessory: board, table, or support device, any type
E0325	10.11	6.69	1.51	Urinal; male, jug-type, any material
E0326	10.50	7.87	1.19	Urinal; female, jug-type, any material
E0441	162.98			Oxygen contents, gaseous (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned), one month's supply = 1 unit
E0442	162.98			Oxygen contents, liquid (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned), one month's supply = 1 unit
E0443	21.41			Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used), one month's supply = 1 unit
E0444	21.41			Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used), one month's supply = 1 unit
E0457	614.51	460.85	61.45	Chest shell (cuirass)
E0484	36.92	27.70	3.69	Oscillatory positive expiratory pressure device, non-electric, any type, each
E0560	171.52	128.64	20.10	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery
E0561	107.00	80.24	10.69	Humidifier, non-heated, used with positive airway pressure device
E0562	301.22	225.91	30.11	Humidifier, heated, used with positive airway pressure device
E0580	134.04	100.52	13.40	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
E0602	29.52	22.14	2.96	Breast pump, manual, any type
E0605	26.43	19.85	2.66	Vaporizer, room type
E0607	66.82	50.10	6.68	Home blood glucose monitor
E0610	202.18	151.66	21.33	Pacemaker monitor, self-contained, checks battery depletion, includes audible and visible check systems
E0615	478.82	359.12	58.50	Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems
E0620	874.39	655.79	87.43	Skin piercing device for collection of capillary blood, laser, each

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
E0621	95.99	72.36	9.25	Sling or seat, patient lift, canvas or nylon
E0627	337.32	253.00	33.74	Seat lift mechanism incorporated into a combination lift-chair mechanism
E0628	337.32	253.00	33.74	Separate seat lift mechanism for use with patient owned furniture - electric
E0629	330.71	248.01	33.08	Separate seat lift mechanism for use with patient owned furniture - nonelectric
E0637	2,104.97	1,578.72	210.51	Combination sit to stand system, any size, with seat lift feature, with or without wheels
E0638	853.57	640.18	85.36	Standing frame system, any size, with or without wheels
E0650	720.22	540.16	88.87	Pneumatic compressor, nonsegmental home model
E0651	780.66	585.50	92.49	Pneumatic compressor, segmental home model without calibrated gradient pressure
E0652	5,301.45	3,972.53	445.36	Pneumatic compressor, segmental home model with calibrated gradient pressure
E0655	101.75	76.30	10.78	Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm
E0660	158.24	118.68	14.14	Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg
E0665	136.99	102.88	13.22	Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm
E0666	138.08	103.59	14.23	Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg
E0667	275.20	206.41	36.56	Segmental pneumatic appliance for use with pneumatic compressor, full leg
E0668	441.88	331.42	43.61	Segmental pneumatic appliance for use with pneumatic compressor, full arm
E0669	174.06	130.56	17.41	Segmental pneumatic appliance for use with pneumatic compressor, half leg
E0671	415.35	311.50	41.54	Segmental gradient pressure pneumatic appliance, full leg
E0672	322.73	242.06	32.28	Segmental gradient pressure pneumatic appliance, full arm
E0673	268.17	201.15	26.82	Segmental gradient pressure pneumatic appliance, half leg
E0691	917.46	688.09	91.75	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less
E0692	1,152.07	864.06	115.20	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four foot panel
E0693	1,420.19	1,065.15	142.02	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, six foot panel
E0694	4,520.31	3,390.26	452.03	Ultraviolet multidirectional light therapy system in six foot cabinet, includes bulbs/lamps, timer and eye protection
E0701	153.35	115.03	15.33	Helmet with face guard and soft interface material, prefabricated
E0720	367.58			TENS, two lead, localized stimulation
E0730	370.56			Transcutaneous electrical nerve stimulation device, four or more leads, for multiple nerve stimulation
E0731	303.19			Form-fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)
E0740	522.87	392.18	52.29	Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer
E0747	3,061.09	2,274.33	304.19	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications
E0748	3,577.94	2,683.47	357.79	Osteogenesis stimulator, electrical, noninvasive, spinal applications
E0752	A.I.			Implantable neurostimulator electrode, each
E0754	A.I.			Patient programmer (external) for use with implantable programmable neurostimulator pulse generator
E0756	A.I.			Implantable neurostimulator pulse generator
E0757	A.I.			Implantable neurostimulator radiofrequency receiver
E0758	A.I.			Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
E0759	A.I.			Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement
E0760	2,973.20	2,229.90	297.33	Osteogenesis stimulator, low intensity ultrasound, non-invasive
E0765	84.13	63.12	8.43	FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting
E0776	143.16	105.33	24.38	IV pole
E0780	10.37			Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours
E0782	A.I.	A.I.	A.I.	Infusion pump, implantable, non-programmable (includes all components, e.g., pump, catheter, connectors, etc.)
E0783	A.I.	A.I.	A.I.	Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.)
E0785	A.I.			Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement
E0786	A.I.	A.I.	A.I.	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)
E0840	73.28	54.93	14.53	Traction frame, attached to headboard, cervical traction
E0850	105.06	78.80	12.27	Traction stand, freestanding, cervical traction
E0855	502.63	376.96	50.26	Cervical traction equipment not requiring additional stand or frame
E0860	38.53	29.51	6.51	Traction equipment, overdoor, cervical
E0870	116.31	87.62	13.40	Traction frame, attached to footboard, extremity traction (e.g., Buck's)
E0880	125.54	95.02	19.71	Traction stand, freestanding, extremity traction (e.g., Buck's)
E0890	120.41	96.99	32.83	Traction frame, attached to footboard, pelvic traction
E0900	128.12	96.12	27.62	Traction stand, freestanding, pelvic traction (e.g., Buck's)
E0942	19.85	14.88	1.99	Cervical head harness/halter
E0943	23.52	17.63	3.24	Cervical pillow
E0944	45.88	34.40	3.97	Pelvic belt/harness/boot
E0945	44.32	34.31	3.77	Extremity belt/harness
E0947	606.46	454.84	62.89	Fracture frame, attachments for complex pelvic traction
E0948	586.59	413.70	58.64	Fracture frame, attachments for complex cervical traction
E0950	88.36	66.27	8.85	Wheelchair accessory, tray, each
E0951	17.08	12.80	1.96	Heel loop/holder, with or without ankle strap, each
E0952	16.89	12.66	1.96	Toe loop/holder, each
E0955	202.18	151.63	20.23	Wheelchair accessory, headrest, cushioned, prefabricated, including fixed mounting hardware, each
E0956	98.58	73.93	9.87	Wheelchair accessory, lateral trunk or hip support, prefabricated, including fixed mounting hardware, each
E0957	137.93	103.45	13.79	Wheelchair accessory, medial thigh support, prefabricated, including fixed mounting hardware, each
E0959	44.21	33.46	3.91	Manual wheelchair accessory, adapter for amputee, each
E0960	90.98	68.24	9.10	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware
E0961	29.74	12.63	2.64	Manual wheelchair accessory, wheel lock brake extension (handle), each
E0962	50.57	37.92	5.18	One-inch cushion, for wheelchair
E0963	60.40	45.41	6.62	Two-inch cushion, for wheelchair

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
E0964	67.39	50.57	6.79	Three-inch cushion, for wheelchair
E0965	72.04	54.04	7.92	Four-inch cushion, for wheelchair
E0966	71.37	53.52	6.62	Manual wheelchair accessory, headrest extension, each
E0967	65.69	49.25	6.57	Manual wheelchair accessory, hand rim with projections, each
E0969	156.63	117.48	13.22	Narrowing device, wheelchair
E0971	65.75	49.31	7.46	Anti-tipping device, wheelchair
E0972	54.89	40.36	5.61	Wheelchair accessory, transfer board or device, each
E0973	114.97	86.23	9.31	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each
E0974	74.07	55.54	7.06	Manual wheelchair accessory, anti-rollback device, each
E0977	65.41	49.08	6.30	Wedge cushion, wheelchair
E0978	42.70	31.66	4.28	Wheelchair accessory, safety belt/pelvic strap, each
E0980	33.06	24.66	3.30	Safety vest, wheelchair
E0981	47.15	35.70	4.08	Wheelchair accessory, seat upholstery, replacement only, each
E0982	51.53	38.64	4.38	Wheelchair accessory, back upholstery, replacement only, each
E0984	1,760.94	1,320.70	176.09	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control
E0985	202.85	152.12	20.30	Wheelchair accessory, seat lift mechanism
E0986	4,864.24	3,648.20	486.43	Manual wheelchair accessory, push-rim activated power assist, each
E0990	117.43	91.75	13.22	Wheelchair accessory, elevating leg rest, complete assembly, each
E0992	95.15	71.37	7.92	Manual wheelchair accessory, solid seat insert
E0994	17.63	13.23	1.78	Armrest, each
E0995	25.84	19.36	2.66	Wheelchair accessory, calf rest/pad, each
E0997	64.07	48.07	7.13	Caster with fork
E0998	34.34	25.77	3.96	Caster without fork
E0999	114.97	86.23	11.51	Pneumatic tire with wheel
E1001	98.06	73.55	10.29	Wheel, single
E1002	4,113.02	3,084.76	411.33	Wheelchair accessory, power seating system, tilt only
E1003	4,391.30	3,293.48	439.14	Wheelchair accessory, power seating system, recline only, without shear reduction
E1004	4,869.05	3,651.77	486.90	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction
E1005	5,270.36	3,952.78	527.03	Wheelchair accessory, power seating system, recline only, with power shear reduction
E1006	6,455.70	4,841.78	645.55	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction
E1007	8,741.27	6,555.94	874.13	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction
E1008	8,742.05	6,556.55	874.20	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction
E1009	I.C.	I.C.	I.C.	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each
E1010	1,151.36	863.51	115.13	Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, each
E1011	I.C.	I.C.	I.C.	Modification to pediatric wheelchair, width adjustment package (not to be dispensed with initial chair)
E1012	507.05	380.30	50.70	Integrated seating system, planar, for pediatric wheelchair

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
E1013	837.93	628.46	83.80	Integrated seating system, contoured, for pediatric wheelchair
E1014	365.14	273.85	36.52	Reclining back, addition to pediatric wheelchair
E1015	114.70	86.02	11.46	Shock absorber for manual wheelchair, each
E1016	131.31	98.48	13.14	Shock absorber for power wheelchair, each
E1017	I.C.	I.C.	I.C.	Heavy duty shock absorber for heavy duty or extra heavy duty manual wheelchair, each
E1018	I.C.	I.C.	I.C.	Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each
E1019	447.26	335.44	44.72	Wheelchair accessory, power seating system, heavy duty feature, patient weight capacity greater than 250 pounds and less than or equal to 400 pounds
E1020	243.41	182.55	24.32	Residual limb support system for wheelchair
E1021	324.16	243.12	32.41	Wheelchair accessory, power seating system, extra heavy duty feature, weight capacity greater than 400 pounds
E1025	125.35	94.02	12.55	Lateral thoracic support, non-contoured, for pediatric wheelchair, each (includes hardware)
E1026	192.90	144.67	19.29	Lateral thoracic support, contoured, for pediatric wheelchair, each (includes hardware)
E1027	275.06	206.28	27.49	Lateral/anterior support, for pediatric wheelchair, each (includes hardware)
E1028	206.54	154.89	20.65	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory
E1029	369.54	277.15	36.95	Wheelchair accessory, ventilator tray, fixed
E1030	1,165.27	873.96	116.53	Wheelchair accessory, ventilator tray, gimbaled
E1065	2,907.25	2,180.44	224.66	Power attachment (to convert any wheelchair to motorized wheelchair, e.g., Solo)
E1161	2,366.09	1,774.57	236.61	Manual adult size wheelchair, includes tilt in space
E1226	463.80	347.82	47.74	Manual wheelchair accessory, fully reclining back, each
E1227	235.88	176.93	23.59	Special height arms for wheelchair
E1230	2,261.79	1,788.81	222.45	Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number
E1231	I.C.	I.C.	I.C.	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system
E1232	2,138.41	1,603.82	213.85	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system
E1233	2,215.73	1,661.79	221.57	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system
E1234	1,928.95	1,446.70	192.91	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system
E1235	1,857.43	1,393.07	185.75	Wheelchair, pediatric size, rigid, adjustable, with seating system
E1236	1,638.73	1,229.05	163.87	Wheelchair, pediatric size, folding, adjustable, with seating system
E1237	1,653.05	1,239.80	165.30	Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238	1,723.55	1,292.64	172.37	Wheelchair, pediatric size, folding, adjustable, without seating system
E1296	491.67	368.75	49.94	Special wheelchair seat height from floor
E1297	88.92	66.68	9.88	Special wheelchair seat depth, by upholstery
E1298	360.10	270.07	36.85	Special wheelchair seat depth and/or width, by construction
E1310	1,825.29	1,368.97	156.12	Whirlpool, nonportable (built-in type)
E1372	163.03	120.68	23.69	Immersion external heater for nebulizer
E1399	I.C.	I.C.	I.C.	Durable medical equipment, miscellaneous
E1700	312.39	234.31	31.23	Jaw motion rehabilitation system
E1701	10.37			Replacement cushions for jaw motion rehabilitation system, package of six
E1702	22.57			Replacement measuring scales for jaw motion rehabilitation system, package of 200
E1820	81.74	61.31	8.17	Replacement soft interface material, dynamic adjustable extension/flexion device
E1821	105.25	78.95	10.51	Replacement soft interface material/cuffs for bi-directional static progressive stretch

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
				device
E2100	643.19	482.40	64.32	Blood glucose monitor with integrated voice synthesizer
E2101	188.56	141.42	18.86	Blood glucose monitor with integrated lancing/blood sample
E2201	373.10	279.83	37.31	Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches
E2202	473.98	355.50	47.40	Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches
E2203	479.05	359.28	47.89	Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches
E2204	813.40	610.05	81.35	Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches
E2310	1,170.24	877.68	117.02	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware
E2311	2,369.20	1,776.90	236.93	Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware
E2320	998.38	748.79	99.84	Power wheelchair accessory, hand or chin control interface, remote joystick or touchpad, proportional, including all related electronics, and fixed mounting hardware
E2321	1,532.90	1,149.68	153.28	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware
E2322	1,410.36	1,057.78	141.03	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware
E2323	64.64	48.48	6.47	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated
E2324	44.49	33.37	4.45	Power wheelchair accessory, chin cup for chin control interface
E2325	1,346.83	1,010.13	134.70	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware
E2326	319.60	239.72	31.96	Power wheelchair accessory, breath tube kit for sip and puff interface
E2327	2,306.14	1,729.58	230.62	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware
E2328	3,877.32	2,908.01	387.74	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware
E2329	1,730.31	1,297.72	173.04	Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware
E2330	3,333.27	2,499.96	333.32	Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware
E2340	314.22	235.67	31.42	Power wheelchair accessory, nonstandard seat frame width, 20-23 inches
E2341	462.97	347.23	46.30	Power wheelchair accessory, nonstandard seat frame width, 24-27 inches
E2342	448.03	336.03	44.80	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches
E2343	259.27	194.44	25.93	Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches
E2351	698.63	523.96	69.88	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface
E2360	112.34	84.26	11.29	Power wheelchair accessory, 22 NF non-sealed lead acid battery, each
E2361	139.47	104.62	13.95	Power wheelchair accessory, 22 NF sealed lead acid battery, each, (e.g. gel cell, absorbed glassmat)

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E2362	91.98	68.98	9.20	Power wheelchair accessory, group 24 non-sealed lead acid battery, each
E2363	186.00	139.50	18.61	Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)
E2364	112.34	84.26	11.29	Power wheelchair accessory, U-1 non-sealed lead acid battery, each
E2365	112.17	84.15	11.22	Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)
E2366	263.62	197.72	26.43	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each
E2367	419.08	314.31	41.91	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each
E2500	391.06	293.29	39.11	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time
E2502	1,195.80	896.86	119.59	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time
E2504	1,577.42	1,183.05	157.76	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
E2506	2,312.96	1,734.69	231.29	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time
E2508	3,576.61	2,682.47	357.67	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device
E2510	6,768.25	5,076.18	676.82	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
E2511	I.C.	I.C.	I.C.	Speech generating software program, for personal computer or personal digital assistant
E2512	I.C.	I.C.	I.C.	Accessory for speech generating device, mounting system
E2599	I.C.			Accessory for speech generating device, not otherwise classified
K0005	1,848.76	1,386.55	184.86	Ultralightweight wheelchair
K0015	181.70	136.27	18.18	Detachable, nonadjustable height armrest, each
K0016	114.97	86.23	9.31	Detachable, adjustable height armrest, complete assembly, each
K0017	51.11	38.33	5.11	Detachable, adjustable height armrest, base, each
K0018	28.55	21.43	2.84	Detachable, adjustable height armrest, upper portion, each
K0019	17.18	12.87	1.71	Arm pad, each
K0020	46.46	34.83	4.65	Fixed, adjustable height armrest, pair
K0022	50.22	37.66	4.25	Reinforced back upholstery
K0023	87.38	65.54	8.75	Solid back insert, planar back, single density foam, attached with straps
K0024	103.92	77.94	10.41	Solid back insert, planar back, single density foam, with adjustable hook-on hardware
K0025	71.37	53.52	6.62	Hook-on headrest extension
K0026	46.50	35.03	3.96	Back upholstery for ultralightweight or high-strength lightweight wheelchair
K0027	46.50	35.03	3.96	Back upholstery for wheelchair type other than ultralightweight or high-strength lightweight wheelchair
K0028	463.80	347.82	47.74	Manual, fully reclining back
K0029	49.75	37.33	4.20	Reinforced seat upholstery
K0030	95.15	71.37	7.92	Solid seat insert, planar seat, single density foam
K0031	42.70	31.66	4.28	Safety belt/pelvic strap, each
K0032	45.88	34.59	3.96	Seat upholstery for ultralightweight or high-strength lightweight wheelchair

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K0033	45.88	34.59	3.96	Seat upholstery for wheelchair type other than ultralightweight or high-strength lightweight wheelchair
K0035	25.90	19.45	2.60	Heel loop with ankle strap, each
K0036	16.89	12.66	1.96	Toe loop, each
K0037	48.16	36.13	3.96	High mount flip-up footrest, each
K0038	24.26	18.20	2.43	Leg strap, each
K0039	53.88	40.41	5.40	Leg strap, H style, each
K0040	74.67	55.99	7.45	Adjustable angle footplate, each
K0041	52.92	39.69	5.31	Large size footplate, each
K0042	36.43	27.32	3.63	Standard size footplate, each
K0043	19.53	14.66	1.95	Footrest, lower extension tube, each
K0044	16.64	12.48	1.67	Footrest, upper hanger bracket, each
K0045	56.62	42.47	5.84	Footrest, complete assembly
K0046	19.53	14.66	1.95	Elevating legrest, lower extension tube, each
K0047	76.48	57.34	7.67	Elevating legrest, upper hanger bracket, each
K0048	117.43	91.75	13.22	Elevating legrest, complete assembly
K0049	25.84	19.36	2.66	Calf pad, each
K0050	32.50	24.39	3.24	Ratchet assembly
K0051	52.61	39.44	5.29	Cam release assembly, footrest or legrest, each
K0052	92.44	69.32	9.24	Swingaway, detachable footrests, each
K0053	102.01	76.51	10.19	Elevating footrests, articulating (telescoping), each
K0054	104.64	78.47	10.46	Seat width of 10, 11, 12, 15, 17, or 20 inches for a high-strength, lightweight or ultralightweight wheelchair
K0055	95.10	71.34	9.51	Seat depth of 15, 17, or 18 inches for a high strength, lightweight or ultralightweight wheelchair
K0056	95.10	71.34	9.51	Seat height less than 17 inches or equal to or greater than 21 inches for a high strength, lightweight, or ultralightweight wheelchair
K0057	124.20	93.14	12.43	Seat width 19 or 20 inches for heavy duty or extra heavy-duty chair
K0058	60.37	45.27	6.04	Seat depth 17 or 18 inches for a motorized/power wheelchair
K0059	31.72	23.79	3.16	Plastic coated handrim, each
K0060	27.75	20.80	2.78	Steel handrim, each
K0061	39.37	29.54	3.94	Aluminum handrim, each
K0062	61.01	45.75	6.12	Handrim with 8 to 10 vertical or oblique projections, each
K0063	81.46	61.08	8.15	Handrim with 12 to 16 vertical or oblique projections, each
K0064	30.41	22.79	3.05	Zero pressure tube (flat free insert), any size, each
K0065	44.46	33.34	4.45	Spoke protectors, each
K0066	28.52	21.81	2.75	Solid tire, any size, each
K0067	40.91	29.30	3.96	Pneumatic tire, any size, each
K0068	5.88	4.42	0.61	Pneumatic tire tube, each
K0069	99.92	74.94	10.41	Rear wheel assembly, complete, with solid tire, spokes or molded, each
K0070	183.16	137.37	18.33	Rear wheel assembly, complete with pneumatic tire, spokes or molded, each
K0071	109.25	81.92	10.93	Front caster assembly, complete, with pneumatic tire, each
K0072	65.76	49.32	6.57	Front caster assembly, complete, with semipneumatic tire, each

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K0073	34.80	26.10	3.48	Caster pin lock, each
K0074	36.00	26.99	3.96	Pneumatic caster tire, any size, each
K0075	40.31	30.24	4.01	Semipneumatic caster tire, any size, each
K0076	25.55	19.18	2.58	Solid caster tire, any size, each
K0077	58.85	44.13	5.88	Front caster assembly, complete, with solid tire, each
K0078	9.60	7.18	0.95	Pneumatic caster tire tube, each
K0079	59.52	25.26	5.29	Wheel lock extension, pair
K0080	148.12	111.09	14.14	Antirollback device, pair
K0081	40.68	30.50	4.06	Wheel lock assembly, complete, each
K0082	112.34	84.26	11.29	22 NF non-sealed lead acid battery, each
K0083	139.47	104.62	13.95	22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)
K0084	91.98	68.98	9.20	Group 24 non-sealed lead acid battery, each
K0085	186.00	139.50	18.61	Group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)
K0086	112.34	84.26	11.29	U-1 non-sealed lead acid battery, each
K0087	112.17	84.15	11.22	U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)
K0088	263.62	197.72	26.43	Battery charger, single mode, for use with only one battery type, sealed or non-sealed
K0089	419.08	314.31	41.91	Battery charger, dual mode, for use with either battery type, sealed or non-sealed
K0090	76.18	57.14	7.63	Rear wheel tire for power wheelchair, any size, each
K0091	20.77	15.57	2.07	Rear wheel tire tube other than zero pressure for power wheelchair, any size, each
K0092	243.13	182.35	24.30	Rear wheel assembly for power wheelchair, complete, each
K0093	151.88	113.91	15.19	Rear wheel zero pressure tire tube (flat free insert) for power wheelchair, any size, each
K0094	49.50	37.11	4.96	Wheel tire for power base, any size, each
K0095	49.50	37.11	4.96	Wheel tire tube other than zero pressure for each base, any size, each
K0096	274.29	205.72	27.42	Wheel assembly for power base, complete, each
K0097	63.09	47.31	6.31	Wheel zero-pressure tire tube (flat free insert) for power base, any size, each
K0098	27.21	20.39	2.72	Drive belt for power wheelchair
K0099	80.91	60.68	8.11	Front caster for power wheelchair
K0100	88.42	66.92	7.78	Wheelchair adapter for amputee, pair
K0102	43.35	32.51	4.34	Crutch and cane holder, each
K0103	54.89	40.36	5.61	Transfer board, less than 25 inches
K0104	118.78	89.09	11.87	Cylinder tank carrier, each
K0105	99.43	74.57	9.93	IV hanger, each
K0106	107.16	80.38	10.74	Arm trough, each
K0107	88.36	66.27	8.85	Wheelchair tray
K0112	244.22			Trunk support device, vest type, with inner frame, prefabricated
K0113	148.98			Trunk support device, vest type, without inner frame, prefabricated
K0114	758.20	568.65	75.84	Back support system for use with a wheelchair, with inner frame, prefabricated
K0115	869.38	652.04	86.96	Seating system, back module, posterior-lateral control, with or without lateral supports, custom fabricated for attachment to wheelchair base
K0116	1,814.60	1,360.97	181.46	Seating system, combined back and seat module, custom fabricated for attachment to wheelchair base
K0268	107.00	80.24	10.69	Humidifier, nonheated, used with positive airway pressure device

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K0452	6.55	4.92	0.56	Wheelchair bearings, any type
K0461	1,760.94	1,320.70	176.09	Power add-on, to convert manual wheelchair to power operated vehicle, tiller control
K0531	301.22	225.91	30.11	Humidifier, heated, used with positive airway pressure device
K0539	27.42			Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each
K0540	24.53			Canister set for negative pressure wound therapy electrical pump, stationary or portable, each
K0541	391.06	293.29	39.11	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to eight minutes recording time
K0543	3,576.61	2,682.47	357.67	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device
K0544	6,768.25	5,076.18	676.82	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
K0545	I.C.	I.C.	I.C.	Speech generating software program, for personal computer or personal digital assistant
K0546	I.C.	I.C.	I.C.	Accessory for speech generating device, mounting system
K0552	2.65			Supplies for external drug infusion pump, syringe type cartridge, sterile, each
K0556	632.69			Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism
K0557	527.21			Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism
K0558	1,035.59			Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557)
K0559	1,035.59			Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557)
K0560	1,756.79			Metacarpal phalangeal joint replacement, two pieces, metal (e.g., stainless steel or cobalt chrome), ceramic-like material (e.g., pyrocarbon), for surgical implantation (all sizes, includes entire system)
K0581	2.75			Ostomy pouch, closed, with barrier attached, with filter (one piece), each
K0582	3.72			Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (one piece), each
K0583	1.81			Ostomy pouch, closed; without barrier attached, with filter (one piece), each
K0584	1.74			Ostomy pouch, closed; for use on barrier with flange, with filter (two piece), each
K0585	I.C.			Ostomy pouch, closed; for use on barrier with locking flange (two piece), each
K0586	1.86			Ostomy pouch, closed; for use on barrier with locking flange, with filter (two piece), each
K0587	4.75			Ostomy pouch, drainable, with barrier attached, with filter (one piece), each
K0588	3.58			Ostomy pouch, drainable; for use on barrier with flange, with filter (two piece system), each
K0589	2.73			Ostomy pouch, drainable; for use on barrier with locking flange (two piece system), each
K0590	2.78			Ostomy pouch, drainable; for use on barrier with locking flange, with filter (two piece system), each

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K0591	6.51			Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (one piece), each
K0592	8.25			Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each
K0593	8.52			Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each
K0594	6.22			Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (one piece), each
K0595	3.59			Ostomy pouch, urinary; for use on barrier with flange, with faucet-type tap with valve (two piece), each
K0596	3.34			Ostomy pouch, urinary; for use on barrier with locking flange (two piece), each
K0597	3.76			Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (two piece), each
K0600	10,177.19	7,632.90	1,017.72	Functional neuromuscular stimulator, transcutaneous stimulation of muscles of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program
K0601	1.10			Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each
K0602	6.36			Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each
K0603	0.57			Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each
K0604	6.09			Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each
K0605	14.60			Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each
K0607	198.31	148.73	19.84	Replacement battery for automated external defibrillator, garment type only, each
K0608	123.76	92.82	12.39	Replacement garment for use with automated external defibrillator, each
K0609	823.02			Replacement electrodes for use with automated external defibrillator, garment type only, each
K0615	1,195.80	896.86	119.59	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time
K0616	1,577.42	1,183.05	157.76	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
K0617	2,312.96	1,734.69	231.29	Speech generating device,digitized speech, using pre-recorded messages, greater than 40 minutes recording time
K0618	603.48			TLSO, sagittal-coronal control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
K0619	397.10			TLSO, sagittal-coronal control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
K0620	1.14			Tubular elastic dressing, any width, per linear yard

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K0621	1.88			Gauze, packing strips non-impregnated, up to 2 inches in width, per linear yard
K0622	0.67			Conforming bandage, non-elastic, knitted/woven, non-sterile width less than three inches, per roll
K0623	1.40			Conforming bandage, non-elastic, knitted/woven, sterile width less than three inches, per roll
K0624	5.82			Light compression bandage, elastic knitted/woven, width less than 3 inches, per roll (at least 3 yards unstretched)
K0625	2.93			Self adherent bandage, elastic, non-knitted/non-woven, load resistance greater than or equal to 0.55 foot pounds at 50% maximum stretch, width less than 3 inches per roll
K0626	7.13			Self adherent bandage, elastic, non-knitted/non-woven, load resistance greater than or equal to 0.55 foot pounds at 50% maximum stretch, width less than 5 inches per roll
K0628	I.C.			For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer of 3/16 inch material of 40 (or higher), prefabricated, each
K0629	I.C.			For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer of higher, includes arch filler and other shaping material, custom fabricated, each
K0630	27.08			Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the scroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment
K0631	I.C.			Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the scroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated
K0632	57.23			Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over sacrum and abdomen, reduces motion about the scroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment
K0633	I.C.			Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over sacrum and abdomen, reduces motion about the scroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated
K0634	55.58			Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, includes fitting and adjustment
K0635	66.09			Lumbar orthosis, saggital control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include paddding, stays, shoulder straps, stays, pendulous abdomen design, prefabricated, includes fitting and adjustment
K0636	355.52			Lumbar orthosis, saggital control, with rigid anterior and posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include paddding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
K0637	62.60			Lumbar-sacral orthosis, flexible, provides lumbar support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, pendulous abdomen design, prefabricated, includes fitting and adjustment
K0638	I.C.			Lumbar-sacral orthosis, flexible, provides lumbar support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on

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				the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated
K0639	137.60			Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
K0640	696.67			Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
K0641	I.C.			Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated
K0642	217.86			Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
K0643	I.C.			Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated
K0644	I.C.			Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment
K0645	I.C.			Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated
K0646	419.89			Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
K0647	1,036.35			Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
K0648	630.01			Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid plastic and stabilizing closures, includes straps,

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				closures, may include soft interface, pendulous abdomen design, prefabricated, includes fitting and adjustment
K0649	822.21			Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid plastic and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated
L0100	433.40			Cranial orthosis (helmet), with or without soft interface, molded to patient model
L0110	116.11			Cranial orthosis (helmet), with or without soft-interface, non-molded
L0112	1,099.77			Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated
L0120	19.97			Cervical, flexible, nonadjustable (foam collar)
L0130	128.17			Cervical, flexible, thermoplastic collar, molded to patient
L0140	62.30			Cervical, semi-rigid, adjustable (plastic collar)
L0150	92.80			Cervical, semi-rigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece)
L0160	157.19			Cervical, semi-rigid, wire frame occipital/mandibular support
L0170	619.05			Cervical, collar, molded to patient model
L0172	95.57			Cervical, collar, semi-rigid thermoplastic foam, two piece
L0174	275.72			Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension
L0180	371.89			Cervical, multiple post collar, occipital/mandibular supports, adjustable
L0190	450.68			Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars (Somi, Guilford, Taylor types)
L0200	422.66			Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars, and thoracic extension
L0210	37.19			Thoracic, rib belt
L0220	100.13			Thoracic, rib belt, custom fabricated
L0450	174.44			TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, includes fitting and adjustment
L0452	I.C.			TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, custom fabricated
L0454	272.52			TLSO flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, includes fitting and adjustment
L0456	781.51			TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, includes fitting and adjustment
L0458	700.77			TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner,

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				restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
L0460	788.75			TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
L0462	981.08			TLSO, triplanar control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
L0464	1,167.97			TLSO, triplanar control, modular segmented spinal system, four rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
L0466	324.45			TLSO, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment
L0468	419.24			TLSO, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal, and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment
L0470	595.43			TLSO, triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal, and transverse planes, produces intracavitary pressure to reduce load on the intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment
L0472	362.79			TLSO, triplanar control, hyperextension, rigid anterior and lateral frame extends from symphysis pubis to sternal notch with two anterior components (one pubic and one sternal), posterior and lateral pads with straps and closures, limits spinal flexion, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment
L0476	736.28			TLSO, sagittal-coronal control, flexion compression jacket, two rigid plastic shells with soft liner, posterior extends from sacrococcygeal junction and terminates at or before the T9 vertebra, anterior extends from symphysis pubis to xiphoid, usually laced together on one side, restricts gross trunk motion in sagittal and coronal planes, allows free flexion and compression of the LS region, includes straps and closures, prefabricated, includes fitting and adjustment
L0478	1,185.93			TLSO, sagittal-coronal control, flexion compression jacket, two rigid plastic shells with soft liner, posterior extends from sacrococcygeal junction and terminates at or before the T9 vertebra, anterior extends from symphysis pubis to xiphoid, usually laced together on

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				one side, restricts gross trunk motion in sagittal and coronal planes, allows free flexion and compression of LS region, includes straps and closures, custom fabricated
L0480	1,253.65			TLSO, triplanar control, one piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated
L0482	1,308.14			TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated
L0484	1,783.66			TLSO, triplanar control, two piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated
L0486	1,892.37			TLSO, triplanar control, two piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated
L0488	788.75			TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, prefabricated, includes fitting and adjustment
L0490	222.28			TLSO, sagittal-coronal control, one piece rigid plastic shell, with overlapping reinforced anterior, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates at or before the T9 vertebra, anterior extends from symphysis pubis to xiphoid, anterior opening, restricts gross trunk motion in sagittal and coronal planes, prefabricated, includes fitting and adjustment
L0500	124.48			Lumbar-sacral-orthosis (LSO), flexible, (lumbo-sacral support)
L0510	276.64			LSO, flexible (lumbo-sacral support), custom fabricated
L0515	239.40			LSO, anterior-posterior control, with rigid or semi-rigid posterior panel, prefabricated
L0520	413.59			LSO, anterior-posterior-lateral control (Knight, Wilcox types), with apron front
L0530	415.81			LSO, anterior-posterior control (Macausland type), with apron front
L0540	409.82			LSO, lumbar flexion (Williams flexion type)
L0550	1,141.11			LSO, anterior-posterior-lateral control, molded to patient model
L0560	1,199.50			LSO, anterior-posterior-lateral control, molded to patient model, with interface material
L0561	271.24			LSO, anterior-posterior-lateral control, with rigid or semi-rigid posterior panel, prefabricated
L0565	920.06			LSO, anterior-posterior-lateral control, custom fitted
L0600	81.32			Sacroiliac, flexible (sacroiliac surgical support)
L0610	259.29			Sacroiliac, flexible (sacroiliac surgical support), custom fabricated

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L0620	318.71			Sacroiliac, semi-rigid (Goldthwaite, Osgood types), with apron front
L0700	1,690.80			CTLSO, anterior-posterior-lateral control, molded to patient model (Minerva type)
L0710	1,824.26			CTLSO, anterior-posterior-lateral control, molded to patient model, with interface material (Minerva type)
L0810	2,545.80			Halo procedure, cervical halo incorporated into jacket vest
L0820	2,168.02			Halo procedure, cervical halo incorporated into plaster body jacket
L0830	2,819.60			Halo procedure, cervical halo incorporated into Milwaukee type orthosis
L0860	974.23			Addition to halo procedure, magnetic resonance image compatible system
L0861	169.36			Addition to halo procedure, replacement liner/interface material
L0960	65.35			Torso support, postsurgical support, pads for postsurgical support
L0970	86.03			TLSO, corset front
L0972	77.47			LSO, corset front
L0974	169.82			TLSO, full corset
L0976	128.66			LSO, full corset
L0978	155.83			Axillary crutch extension
L0980	17.53			Peroneal straps, pair
L0982	16.34			Stocking supporter grips, set of four (4)
L0984	51.48			Protective body sock, each
L1000	1,928.38			CTLSO (Milwaukee), inclusive of furnishing initial orthosis, including model
L1005	2,514.93			Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment
L1010	55.75			Addition to CTLSO or scoliosis orthosis, axilla sling
L1020	65.06			Addition to CTLSO or scoliosis orthosis, kyphosis pad
L1025	100.80			Addition to CTLSO or scoliosis orthosis, kyphosis pad, floating
L1030	47.89			Addition to CTLSO or scoliosis orthosis, lumbar bolster pad
L1040	58.73			Addition to CTLSO or scoliosis orthosis, lumbar or lumbar rib pad
L1050	62.67			Addition to CTLSO or scoliosis orthosis, sternal pad
L1060	74.84			Addition to CTLSO or scoliosis orthosis, thoracic pad
L1070	67.73			Addition to CTLSO or scoliosis orthosis, trapezius sling
L1080	44.34			Addition to CTLSO or scoliosis orthosis, outrigger
L1085	115.87			Addition to CTLSO or scoliosis orthosis, outrigger, bilateral with vertical extensions
L1090	69.00			Addition to CTLSO or scoliosis orthosis, lumbar sling
L1100	145.59			Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather
L1110	226.88			Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather, molded to patient model
L1120	29.90			Addition to CTLSO, scoliosis orthosis, cover for upright, each
L1200	1,400.04			TLSO, inclusive of furnishing initial orthosis only
L1210	196.97			Addition to TLSO, (low profile), lateral thoracic extension

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L1220	166.77			Addition to TLSO, (low profile), anterior thoracic extension
L1230	481.15			Addition to TLSO, (low profile), Milwaukee type superstructure
L1240	63.54			Addition to TLSO, (low profile), lumbar derotation pad
L1250	63.50			Addition to TLSO, (low profile), anterior ASIS pad
L1260	63.54			Addition to TLSO, (low profile), anterior thoracic derotation pad
L1270	63.54			Addition to TLSO, (low profile), abdominal pad
L1280	86.58			Addition to TLSO, (low profile), rib gusset (elastic), each
L1290	63.54			Addition to TLSO, (low profile), lateral trochanteric pad
L1300	1,337.57			Other scoliosis procedure, body jacket molded to patient model
L1310	1,439.58			Other scoliosis procedure, postoperative body jacket
L1500	1,881.66			THKAO, mobility frame (Newington, Parapodium types)
L1510	1,111.94			THKAO, standing frame, with or without tray and accessories
L1520	1,865.39			THKAO, swivel walker
L1600	116.57			HO, abduction control of hip joints, flexible, Frejka type with cover, prefabricated, includes fitting and adjustment
L1610	35.71			HO, abduction control of hip joints, flexible, (Frejka cover only), prefabricated, includes fitting and adjustment
L1620	118.65			HO, abduction control of hip joints, flexible, (Pavlik harness), prefabricated, includes fitting and adjustment
L1630	170.08			HO, abduction control of hip joints, semi-flexible (Von Rosen type), custom fabricated
L1640	463.13			HO, abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs, custom fabricated
L1650	230.54			HO, abduction control of hip joints, static, adjustable (Ilfled type), prefabricated, includes fitting and adjustment
L1652	280.10			Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, any type
L1660	158.38			HO, abduction control of hip joints, static, plastic, prefabricated, includes fitting and adjustment
L1680	917.18			HO, abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thigh cuffs (Rancho hip action type), custom fabricated
L1685	1,193.85			HO, abduction control of hip joint, postoperative hip abduction type, custom fabricated
L1686	757.05			HO, abduction control of hip joint, postoperative hip abduction type, prefabricated, includes fitting and adjustments
L1690	1,519.45			Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control, prefabricated, includes fitting and adjustment
L1700	1,460.73			Legg Perthes orthosis, (Toronto type), custom fabricated
L1710	1,794.22			Legg Perthes orthosis, (Newington type), custom fabricated
L1720	1,014.66			Legg Perthes orthosis, trilateral, (Tachdijan type), custom fabricated
L1730	1,066.76			Legg Perthes orthosis, (Scottish Rite type), custom fabricated
L1750	148.10			Legg Perthes orthosis, Legg Perthes sling (Sam Brown type), prefabricated, includes fitting and adjustment

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L1755	1,589.06			Legg Perthes orthosis, (Patten bottom type), custom fabricated
L1800	50.07			KO, elastic with stays, prefabricated, includes fitting and adjustment
L1810	77.81			KO, elastic with joints, prefabricated, includes fitting and adjustment
L1815	97.23			KO, elastic or other elastic type material with condylar pad(s), prefabricated, includes fitting and adjustment
L1820	114.58			KO, elastic with condylar pads and joints, prefabricated, includes fitting and adjustment
L1825	53.70			KO, elastic knee cap, prefabricated, includes fitting and adjustment
L1830	65.85			KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment
L1831	231.26			Knee orthosis, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment
L1832	597.55			KO, adjustable knee joints, positional orthosis, rigid support, prefabricated, includes fitting and adjustment
L1834	779.11			KO, without knee joint, rigid, custom fabricated
L1836	104.84			Knee orthosis, rigid, without joint(s), includes soft interface material, prefabricated, includes fitting and adjustment
L1840	734.26			KO, derotation, medial-lateral, anterior cruciate ligament, custom fabricated
L1843	705.03			Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, includes fitting and adjustment
L1844	1,285.64			Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated
L1845	655.59			KO, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, prefabricated, includes fitting and adjustment
L1846	877.53			KO, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, custom fabricated
L1847	451.94			KO, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, includes fitting and adjustment
L1850	266.49			KO, Swedish type, prefabricated, includes fitting and adjustment
L1855	1,082.38			KO, molded plastic, thigh and calf sections, with double upright knee joints, custom fabricated
L1858	1,034.68			KO, molded plastic, polycentric knee joints, pneumatic knee pads (CTI), custom fabricated
L1860	854.01			KO, modification of supracondylar prosthetic socket, custom fabricated (SK)
L1870	866.45			KO, double upright, thigh and calf lacers, with knee joints, custom fabricated
L1880	594.32			KO, double upright, nonmolded thigh and calf cuffs/lacers with knee joints, custom fabricated
L1885	854.13			KO, single or double upright, thigh and calf, with funtional active resistance control, prefabricated, includes fitting and adjustment
L1900	239.09			AFO, spring wire, dorsiflexion assist calf band, custom fabricated
L1901	13.91			Ankle orthosis, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, lycra)
L1902	69.21			AFO, ankle gauntlet, prefabricated, includes fitting and adjustment
L1904	471.98			AFO, molded ankle gauntlet, custom fabricated

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L1906	101.37			AFO, multiligamentus ankle support, prefabricated, includes fitting and adjustment
L1907	442.14			AFO, supramalleolar with straps, with or without interface/pads, custom fabricated
L1910	238.66			AFO, posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and adjustment
L1920	349.75			AFO, single upright with static or adjustable stop (Phelps or Perlstein type), custom fabricated
L1930	205.51			AFO, plastic or other material, prefabricated, includes fitting and adjustment
L1940	496.37			AFO, plastic or other material, custom-fabricated
L1945	929.10			AFO, molded to patient model, plastic, rigid anterior tibial section (floor reaction), custom fabricated
L1950	717.88			AFO, spiral, (Institute of Rehabilitative Medicine type), plastic, custom-fabricated
L1951	659.91			AFO, spiral, (Institute of Rehabilitative Medicine type), plastic or other material, prefabricated, includes fitting and adjustment
L1960	556.33			AFO, posterior solid ankle, plastic, custom fabricated
L1970	714.18			AFO, plastic, with ankle joint, custom fabricated
L1971	368.30			AFO, plastic or other material with ankle joint, prefabricated, includes fitting and adjustment
L1980	357.36			AFO, single upright free plantar dorsiflexion, solid stirrup, calf band/cuff (single bar BK" orthosis)
L1990	425.15			AFO, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar BK" orthosis)
L2000	866.78			KAFO, single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar AK" orthosis)
L2010	787.83			KAFO, single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar AK" orthosis)
L2020	1,117.90			KAFO, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar AK" orthosis)
L2030	906.67			KAFO, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar AK" orthosis)
L2035	138.45			KAFO, full plastic, static, (pediatric size), prefabricated, includes fitting and adjustment
L2036	1,862.14			KAFO, full plastic, double upright, free knee, custom fabricated
L2037	1,671.72			KAFO, full plastic, single upright, free knee, custom fabricated
L2038	1,434.99			KAFO, full plastic, without knee joint, multiaxis ankle, (Lively orthosis or equal), custom fabricated
L2039	1,746.25			KAFO, full plastic, single upright, poly-axial hinge, medial lateral rotation control, custom fabricated
L2040	170.87			HKAFO, torsion control, bilateral rotation straps, pelvic band/belt, custom fabricated
L2050	478.11			HKAFO, torsion control, bilateral torsion cables, hip joint, pelvic band/belt, custom fabricated
L2060	486.69			HKAFO, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/ belt, custom fabricated
L2070	117.50			HKAFO, torsion control, unilateral rotation straps, pelvic band/belt, custom fabricated
L2080	361.00			HKAFO, torsion control, unilateral torsion cable, hip joint, pelvic band/belt, custom

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				fabricated
L2090	346.94			HKAFO, torsion control, unilateral torsion cable, ball bearing hip joint, pelvic band/belt, custom fabricated
L2106	682.41			AFO, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, custom fabricated
L2108	1,036.68			AFO, fracture orthosis, tibial fracture cast orthosis, custom fabricated
L2112	425.52			AFO, fracture orthosis, tibial fracture orthosis, soft, prefabricated, includes fitting and adjustment
L2114	513.97			AFO, fracture orthosis, tibial fracture orthosis, semi-rigid, prefabricated, includes fitting and adjustment
L2116	660.05			AFO, fracture orthosis, tibial fracture orthosis, rigid, prefabricated, includes fitting and adjustment
L2126	1,080.94			KAFO, fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, custom fabricated
L2128	1,721.03			KAFO, fracture orthosis, femoral fracture cast orthosis, custom fabricated
L2132	635.87			KAFO, fracture orthosis, femoral fracture cast orthosis, soft, prefabricated, includes fitting and adjustment
L2134	895.10			KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid, prefabricated, includes fitting and adjustment
L2136	1,000.51			KAFO, fracture orthosis, femoral fracture cast orthosis, rigid, prefabricated, includes fitting and adjustment
L2180	103.99			Addition to lower extremity fracture orthosis, plastic shoe insert with ankle joints
L2182	91.95			Addition to lower extremity fracture orthosis, drop lock knee joint
L2184	96.52			Addition to lower extremity fracture orthosis, limited motion knee joint
L2186	116.51			Addition to lower extremity fracture orthosis, adjustable motion knee joint, Lerman type
L2188	282.86			Addition to lower extremity fracture orthosis, quadrilateral brim
L2190	87.65			Addition to lower extremity fracture orthosis, waist belt
L2192	324.21			Addition to lower extremity fracture orthosis, hip joint, pelvic band, thigh flange, and pelvic belt
L2200	35.79			Addition to lower extremity, limited ankle motion, each joint
L2210	50.60			Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint
L2220	61.65			Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint
L2230	57.76			Addition to lower extremity, split flat caliper stirrups and plate attachment
L2240	77.46			Addition to lower extremity, round caliper and plate attachment
L2250	267.48			Addition to lower extremity, foot plate, molded to patient model, stirrup attachment
L2260	150.90			Addition to lower extremity, reinforced solid stirrup (Scott-Craig type)
L2265	118.20			Addition to lower extremity, long tongue stirrup
L2270	47.27			Addition to lower extremity, varus/valgus correction (T") strap
L2275	99.11			Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined
L2280	376.09			Addition to lower extremity, molded inner boot
L2300	202.67			Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
L2310	92.60			Addition to lower extremity, abduction bar, straight
L2320	189.85			Addition to lower extremity, nonmolded lacer
L2330	330.77			Addition to lower extremity, lacer molded to patient model
L2335	225.96			Addition to lower extremity, anterior swing band
L2340	336.43			Addition to lower extremity, pretibial shell, molded to patient model
L2350	670.74			Addition to lower extremity, prosthetic type, (BK) socket, molded to patient model, (used for PTB
L2360	38.95			Addition to lower extremity, extended steel shank
L2370	193.24			Addition to lower extremity, Patten bottom
L2375	91.09			Addition to lower extremity, torsion control, ankle joint and half solid stirrup
L2380	92.67			Addition to lower extremity, torsion control, straight knee joint, each joint
L2385	128.51			Addition to lower extremity, straight knee joint, heavy duty, each joint
L2390	109.86			Addition to lower extremity, offset knee joint, each joint
L2395	157.03			Addition to lower extremity, offset knee joint, heavy duty, each joint
L2397	92.82			Addition to lower extremity orthosis, suspension sleeve
L2405	68.50			Addition to knee joint, lock; drop, stance or swing phase, each joint
L2415	95.43			Addition to knee lock with integrated release mechanism (bail, cable, or equal), any material, each joint
L2425	112.64			Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint
L2430	112.64			Addition to knee joint, ratchet lock for active and progressive knee extension, each joint
L2435	166.10			Addition to knee joint, polycentric joint, each joint
L2492	89.30			Addition to knee joint, lift loop for drop lock ring
L2500	316.63			Addition to lower extremity, thigh/weight bearing, gluteal/ischial weight bearing, ring
L2510	608.93			Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, molded to patient model
L2520	448.54			Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, custom fitted
L2525	1,223.47			Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim molded to patient model
L2526	664.89			Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim, custom fitted
L2530	200.59			Addition to lower extremity, thigh/weight bearing, lacer, nonmolded
L2540	424.34			Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model
L2550	216.19			Addition to lower extremity, thigh/weight bearing, high roll cuff
L2570	358.55			Addition to lower extremity, pelvic control, hip joint, Clevis type, two position joint, each
L2580	389.81			Addition to lower extremity, pelvic control, pelvic sling
L2600	154.60			Addition to lower extremity, pelvic control, hip joint, Clevis type, or thrust bearing, free, each
L2610	182.81			Addition to lower extremity, pelvic control, hip joint, Clevis or thrust bearing, lock, each
L2620	268.36			Addition to lower extremity, pelvic control, hip joint, heavy-duty, each

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
L2622	307.63			Addition to lower extremity, pelvic control, hip joint, adjustable flexion, each
L2624	249.27			Addition to lower extremity, pelvic control, hip joint, adjustable flexion, extension, abduction control, each
L2627	1,720.59			Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables
L2628	1,470.70			Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables
L2630	231.10			Addition to lower extremity, pelvic control, band and belt, unilateral
L2640	331.26			Addition to lower extremity, pelvic control, band and belt, bilateral
L2650	90.58			Addition to lower extremity, pelvic and thoracic control, gluteal pad, each
L2660	186.83			Addition to lower extremity, thoracic control, thoracic band
L2670	128.41			Addition to lower extremity, thoracic control, paraspinal uprights
L2680	117.80			Addition to lower extremity, thoracic control, lateral support uprights
L2750	83.89			Addition to lower extremity orthosis, plating chrome or nickel, per bar
L2755	102.64			Addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, per segment
L2760	45.73			Addition to lower extremity orthosis, extension, per extension, per bar (for lineal adjustment for growth)
L2768	102.38			Orthotic side bar disconnect device, per bar
L2770	46.48			Addition to lower extremity orthosis, any material, per bar or joint
L2780	67.92			Addition to lower extremity orthosis, noncorrosive finish, per bar
L2785	25.80			Addition to lower extremity orthosis, drop lock retainer, each
L2795	85.28			Addition to lower extremity orthosis, knee control, full kneecap
L2800	107.06			Addition to lower extremity orthosis, knee control, kneecap, medial or lateral pull
L2810	78.39			Addition to lower extremity orthosis, knee control, condylar pad
L2820	86.80			Addition to lower extremity orthosis, soft interface for molded plastic, below knee section
L2830	94.30			Addition to lower extremity orthosis, soft interface for molded plastic, above knee section
L2840	33.01			Addition to lower extremity orthosis, tibial length sock, fracture or equal, each
L2850	59.68			Addition to lower extremity orthosis, femoral length sock, fracture or equal, each
L3224	56.10			Orthopedic footwear, woman's shoe, oxford, used as an integral part of a brace (orthosis)
L3225	67.89			Orthopedic footwear, man's shoe, oxford, used as an integral part of a brace (orthosis)
L3650	54.15			SO, figure of eight design abduction re- strainer, prefabricated, includes fitting and adjustment
L3651	47.09			Shoulder orthosis, single shoulder, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, lycra)
L3652	141.90			Shoulder orthosis, double shoulder, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, lycra)
L3660	100.95			SO, figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment
L3670	83.30			SO, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment

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L3675	125.49			SO, vest type abduction restrainer, canvas webbing type, or equal, prefabricated, includes fitting and adjustment
L3700	51.42			EO, elastic with stays, prefabricated, includes fitting and adjustment
L3701	14.56			Elbow orthosis, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, lycra)
L3710	114.35			EO, elastic with metal joints, prefabricated, includes fitting and adjustment
L3720	481.80			EO, double upright with forearm/arm cuffs, free motion, custom fabricated
L3730	885.36			EO, double upright with forearm/arm cuffs, extension/flexion assist, custom fabricated
L3740	1,049.67			EO, double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated
L3760	357.62			Elbow orthosis, with adjustable position locking joint(s), prefabricated, includes fitting and adjustments, any type
L3762	76.89			Elbow orthosis, rigid, without joints, includes soft interface material, prefabricated, includes fitting and adjustment
L3800	165.72			WHFO, short opponens, no attachments, custom fabricated
L3805	272.87			WHFO, long opponens, no attachment, custom fabricated
L3807	178.81			WHFO, without joint(s), prefabricated, includes fitting and adjustments, any type
L3810	47.74			WHFO, addition to short and long opponens, thumb abduction (C") bar"
L3815	45.18			WHFO, addition to short and long opponens, second M.P. abduction assist
L3820	76.12			WHFO, addition to short and long opponens, I.P. extension assist, with M.P. extension stop
L3825	47.77			WHFO, addition to short and long opponens, M.P. extension stop
L3830	65.73			WHFO, addition to short and long opponens, M.P. extension assist
L3835	69.46			WHFO, addition to short and long opponens, M.P. spring extension assist
L3840	52.83			WHFO, addition to short and long opponens, spring swivel thumb
L3845	59.80			WHFO, addition to short and long opponens, thumb I.P. extension assist, with M.P. stop
L3850	101.16			WHO, addition to short and long opponens, action wrist, with dorsiflexion assist
L3855	86.10			WHFO, addition to short and long opponens, adjustable M.P. flexion control
L3860	117.86			WHFO, addition to short and long opponens, adjustable M.P. flexion control and I.P.
L3900	958.33			WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven, custom fabricated
L3901	1,183.75			WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven, custom fabricated
L3904	2,269.86			WHFO, external powered, electric, custom fabricated
L3906	345.55			WHO, wrist gauntlet, molded to patient model, custom fabricated
L3907	498.90			WHFO, wrist gauntlet with thumb spica, molded to patient model, custom fabricated
L3908	58.85			WHO, wrist extension control cock-up, nonmolded, prefabricated, includes fitting and adjustment
L3909	10.09			Wrist orthosis, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, lycra)
L3910	321.21			WHFO, Swanson design, prefabricated, includes fitting and adjustment

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L3911	17.71			Wrist hand finger orthosis, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, lycra)
L3912	69.86			HFO, flexion glove with elastic finger control, prefabricated, includes fitting and adjustment
L3914	69.05			WHO, wrist extension cock-up, prefabricated, includes fitting and adjustment
L3916	103.43			WHFO, wrist extension cock-up, with outrigger, prefabricated, includes fitting and adjustment
L3917	75.54			Hand orthosis, metacarpal fracture orthosis, prefabricated, includes fitting and adjustment
L3918	58.26			HFO, knuckle bender, prefabricated, includes fitting and adjustment
L3920	93.57			HFO, knuckle bender, with outrigger, prefabricated, includes fitting and adjustment
L3922	72.03			HFO, knuckle bender, two segment to flex joints, prefabricated, includes fitting and adjustment
L3923	27.82			HFO, without joint(s), prefabricated, includes fitting and adjustments, any type
L3924	78.54			WHFO, Oppenheimer, prefabricated, includes fitting and adjustment
L3926	68.38			WHFO, Thomas suspension, prefabricated, includes fitting and adjustment
L3928	48.86			HFO, finger extension, with clock spring, prefabricated, includes fitting and adjustment
L3930	47.23			WHFO, finger extension, with wrist support, prefabricated, includes fitting and adjustment
L3932	34.62			FO, safety pin, spring wire, prefabricated, includes fitting and adjustment
L3934	36.33			FO, safety pin, modified, prefabricated, includes fitting and adjustment
L3936	74.90			WHFO, Palmer, prefabricated, includes fitting and adjustment
L3938	77.25			WHFO, dorsal wrist, prefabricated, includes fitting and adjustment
L3940	94.46			WHFO, dorsal wrist, with outrigger attachment, prefabricated, includes fitting and adjustment
L3942	61.11			HFO, reverse knuckle bender, prefabricated, includes fitting and adjustment
L3944	74.12			HFO, reverse knuckle bender, with outrigger, prefabricated, includes fitting and adjustment
L3946	65.28			HFO, composite elastic, prefabricated, includes fitting and adjustment
L3948	48.73			FO, finger knuckle bender, prefabricated, includes fitting and adjustment
L3950	110.46			WHFO, combination Oppenheimer, with knuckle bender and two attachments, prefabricated, includes fitting and adjustment
L3952	122.60			WHFO, combination Oppenheimer, with reverse knuckle and two attachments, prefabricated, includes fitting and adjustment
L3954	108.46			HFO, spreading hand, prefabricated, includes fitting and adjustment
L3956	I.C.			Addition of joint to upper extremity orthosis, any material; per joint
L3960	643.20			SEWHO, abduction positioning, airplane design, prefabricated, includes fitting and adjustment
L3962	704.68			SEWHO, abduction positioning, Erb's palsy design, prefabricated, includes fitting and adjustment
L3963	1,638.53			SEWHO, molded shoulder, arm, forearm, and wrist, with articulating elbow joint, custom fabricated
L3964	621.11	465.80	62.10	SEO, mobile arm support attached to wheelchair, balanced, adjustable, prefabricated, includes fitting and adjustment

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L3965	991.11	743.33	99.13	SEO, mobile arm support attached to wheelchair, balanced, adjustable Rancho type, prefabricated, includes fitting and adjustment
L3966	746.64	559.98	74.67	SEO, mobile arm support attached to wheelchair, balanced, reclining, prefabricated, includes fitting and adjustment
L3968	858.96	644.22	85.89	SEO, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints), prefabricated, includes fitting and adjustment
L3969	660.74	495.54	66.08	SEO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support, prefabricated, includes fitting and adjustment
L3970	224.66	168.50	22.47	SEO, addition to mobile arm support, elevating proximal arm
L3972	168.07	126.05	16.81	SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control
L3974	142.55	106.91	14.27	SEO, addition to mobile arm support, supinator
L3980	303.63			Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment
L3982	320.02			Upper extremity fracture orthosis, radius/ulnar, prefabricated, includes fitting and adjustment
L3984	318.35			Upper extremity fracture orthosis, wrist, prefabricated, includes fitting and adjustment
L3985	574.04			Upper extremity fracture orthosis, forearm, hand with wrist hinge, custom fabricated
L3986	443.81			Upper extremity fracture orthosis, combination of humeral, radius/ulnar, wrist (example: Colles' fracture), custom fabricated
L3995	32.12			Addition to upper extremity orthosis, sock, fracture or equal, each
L4000	1,150.48			Replace girdle for spinal orthosis (CTLSO or SO)
L4010	505.19			Replace trilateral socket brim
L4020	654.92			Replace quadrilateral socket brim, molded to patient model
L4030	380.05			Replace quadrilateral socket brim, custom fitted
L4040	336.42			Replace molded thigh lacer
L4045	329.24			Replace nonmolded thigh lacer
L4050	378.51			Replace molded calf lacer
L4055	268.31			Replace nonmolded calf lacer
L4060	250.53			Replace high roll cuff
L4070	237.16			Replace proximal and distal upright for KAFO
L4080	101.52			Replace metal bands KAFO, proximal thigh
L4090	79.07			Replace metal bands KAFO-AFO, calf or distal thigh
L4100	88.85			Replace leather cuff KAFO, proximal thigh
L4110	76.38			Replace leather cuff KAFO-AFO, calf or distal thigh
L4130	373.47			Replace pretibial shell
L4350	78.16			Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel), prefabricated, includes fitting and adjustment
L4360	277.90			Walking boot, pneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment
L4370	189.48			Pneumatic full leg splint, prefabricated, includes fitting and adjustment

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L4380	107.81			Pneumatic knee splint, prefabricated, includes fitting and adjustment
L4386	124.58			Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment
L4392	19.31			Replacement soft interface material, static AFO
L4394	14.09			Replace soft interface material, foot drop splint
L4396	137.75			Static ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, pressure reduction, may be used for minimal ambulation, prefabricated, includes fitting and adjustment
L4398	63.41			Foot drop splint, recumbent positioning device, prefabricated, includes fitting and adjustment
L5000	405.20			Partial foot, shoe insert with longitudinal arch, toe filler
L5010	982.16			Partial foot, molded socket, ankle height, with toe filler
L5020	1,670.97			Partial foot, molded socket, tibial tubercle height, with toe filler
L5050	2,184.86			Ankle, Symes, molded socket, SACH foot
L5060	2,215.04			Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot
L5100	2,240.39			Below knee, molded socket, shin, SACH foot
L5105	3,412.31			Below knee, plastic socket, joints and thigh lacer, SACH foot
L5150	2,880.81			Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot
L5160	3,378.31			Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, SACH foot
L5200	3,359.54			Above knee, molded socket, single axis constant friction knee, shin, SACH foot
L5210	2,115.46			Above knee, short prosthesis, no knee joint (stubbies")
L5220	2,270.47			Above knee, short prosthesis, no knee joint (stubbies")
L5230	3,200.94			Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot
L5250	4,468.25			Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5270	4,797.22			Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot
L5280	4,805.39			Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5301	1,967.25			Below knee, molded socket, shin, SACH foot, endoskeletal system
L5311	2,645.29			Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot, endoskeletal system
L5321	2,775.26			Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee
L5331	4,135.50			Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot
L5341	4,053.11			Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot
L5400	965.20			Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee

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L5410	368.56			Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, below knee, each additional cast change and realignment
L5420	1,219.01			Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension and one cast change AK" or knee disarticulation"
L5430	422.21			Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, AK" or knee disarticulation
L5450	326.73			Immediate postsurgical or early fitting, application of nonweight bearing rigid dressing, below knee
L5460	480.38			Immediate postsurgical or early fitting, application of nonweight bearing rigid dressing, above knee
L5500	1,173.06			Initial, below knee PTB" type socket
L5505	1,642.05			Initial, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot plaster socket, direct formed
L5510	1,462.48			Preparatory, below knee PTB" type socket
L5520	1,531.71			Preparatory, below knee PTB" type socket
L5530	1,669.13			Preparatory, below knee PTB" type socket
L5535	1,741.24			Preparatory, below knee PTB" type socket
L5540	1,655.61			Preparatory, below knee PTB" type socket
L5560	1,576.83			Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model
L5570	1,901.69			Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5580	1,972.26			Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5585	2,207.67			Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket
L5590	2,224.04			Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model
L5595	3,966.03			Preparatory, hip disarticulation - hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model
L5600	4,689.69			Preparatory, hip disarticulation - hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model
L5610	1,983.98			Addition to lower extremity, endoskeletal system, above knee, hydracadence system
L5611	1,722.82			Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4-bar linkage, with friction swing phase control
L5613	2,620.51			Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4-bar linkage, with hydraulic swing phase control
L5614	1,328.51			Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4-bar linkage, with pneumatic swing phase control
L5616	1,229.62			Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control
L5617	462.72			Addition to lower extremity, quick change self-aligning unit, above or below knee, each
L5618	300.72			Addition to lower extremity, test socket, Symes

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L5620	297.28			Addition to lower extremity, test socket, below knee
L5622	362.40			Addition to lower extremity, test socket, knee disarticulation
L5624	388.75			Addition to lower extremity, test socket, above knee
L5626	462.95			Addition to lower extremity, test socket, hip disarticulation
L5628	438.64			Addition to lower extremity, test socket, hemipelvectomy
L5629	339.82			Addition to lower extremity, below knee, acrylic socket
L5630	409.86			Addition to lower extremity, Symes type, expandable wall socket
L5631	469.82			Addition to lower extremity, above knee or knee disarticulation, acrylic socket
L5632	202.95			Addition to lower extremity, Symes type, PTB" brim design socket"
L5634	317.39			Addition to lower extremity, Symes type, posterior opening (Canadian) socket
L5636	272.46			Addition to lower extremity, Symes type, medial opening socket
L5637	266.74			Addition to lower extremity, below knee, total contact
L5638	390.29			Addition to lower extremity, below knee, leather socket
L5639	1,198.87			Addition to lower extremity, below knee, wood socket
L5640	512.81			Addition to lower extremity, knee disarticulation, leather socket
L5642	496.87			Addition to lower extremity, above knee, leather socket
L5643	1,664.29			Addition to lower extremity, hip disarticulation, flexible inner socket, external frame
L5644	621.56			Addition to lower extremity, above knee, wood socket
L5645	712.65			Addition to lower extremity, below knee, flexible inner socket, external frame
L5646	585.88			Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket
L5647	850.58			Addition to lower extremity, below knee, suction socket
L5648	528.00			Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket
L5649	1,526.90			Addition to lower extremity, ischial containment/narrow M-L socket
L5650	391.51			Addition to lower extremity, total contact, above knee or knee disarticulation socket
L5651	1,284.13			Addition to lower extremity, above knee, flexible inner socket, external frame
L5652	432.01			Addition to lower extremity, suction suspension, above knee or knee disarticulation socket
L5653	488.75			Addition to lower extremity, knee disarticulation, expandable wall socket
L5654	354.62			Addition to lower extremity, socket insert, Symes (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5655	253.14			Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5656	300.37			Addition to lower extremity, socket insert, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5658	339.08			Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5661	650.71			Addition to lower extremity, socket insert, multidurometer, Symes
L5665	547.51			Addition to lower extremity, socket insert, multidurometer, below knee
L5666	68.53			Addition to lower extremity, below knee, cuff suspension

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L5668	99.36			Addition to lower extremity, below knee, molded distal cushion
L5670	231.13			Addition to lower extremity, below knee, molded supracondylar suspension (PTS" or similar)"
L5671	398.91			Addition to lower extremity, below knee/above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert
L5672	281.17			Addition to lower extremity, below knee, removable medial brim suspension
L5674	56.40			Addition to lower extremity, below knee, suspension sleeve, any material, each
L5675	92.63			Addition to lower extremity, below knee, suspension sleeve, heavy duty, any material, each
L5676	380.67			Addition to lower extremity, below knee, knee joints, single axis, pair
L5677	527.22			Addition to lower extremity, below knee, knee joints, polycentric, pair
L5678	31.84			Addition to lower extremity, below knee joint covers, pair
L5680	277.12			Addition to lower extremity, below knee, thigh lacer, nonmolded
L5681	1,035.59			Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679)
L5682	668.73			Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded
L5683	1,035.59			Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679)
L5684	48.35			Addition to lower extremity, below knee, fork strap
L5686	48.29			Addition to lower extremity, below knee, back check (extension control)
L5688	56.95			Addition to lower extremity, below knee, waist belt, webbing
L5690	104.63			Addition to lower extremity, below knee, waist belt, padded and lined
L5692	126.05			Addition to lower extremity, above knee, pelvic control belt, light
L5694	193.98			Addition to lower extremity, above knee, pelvic control belt, padded and lined
L5695	147.25			Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each
L5696	190.15			Addition to lower extremity, above knee or knee disarticulation, pelvic joint
L5697	85.84			Addition to lower extremity, above knee or knee disarticulation, pelvic band
L5698	96.36			Addition to lower extremity, above knee or knee disarticulation, Silesian bandage
L5699	193.44			All lower extremity prostheses, shoulder harness
L5700	2,336.86			Replacement, socket, below knee, molded to patient model
L5701	2,899.08			Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model
L5702	3,653.84			Replacement, socket, hip disarticulation, including hip joint, molded to patient model
L5704	476.49			Custom shaped protective cover, below knee
L5705	873.54			Custom shaped protective cover, above knee
L5706	852.05			Custom shaped protective cover, knee disarticulation

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
L5707	1,144.71			Custom shaped protective cover, hip disarticulation
L5710	325.69			Addition, exoskeletal knee-shin system, single axis, manual lock
L5711	546.33			Addition, exoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5712	434.09			Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)
L5714	390.82			Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control
L5716	702.19			Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock
L5718	843.44			Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control
L5722	791.34			Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5724	1,455.62			Addition, exoskeletal knee-shin system, single axis, fluid swing phase control
L5726	1,808.24			Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control
L5728	2,544.37			Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5780	978.55			Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control
L5781	3,150.08			Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system
L5782	3,320.90			Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty
L5785	555.55			Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5790	768.85			Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
L5795	1,148.09			Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5810	520.60			Addition, endoskeletal knee-shin system, single axis, manual lock
L5811	779.85			Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5812	589.94			Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)
L5814	2,923.87			Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock
L5816	735.44			Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock
L5818	1,026.87			Addition, endoskeletal knee-shin system, polycentric, friction swing and stance phase control
L5822	1,820.90			Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5824	1,428.96			Addition, endoskeletal knee-shin system, single axis, fluid swing phase control
L5826	2,500.45			Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame
L5828	3,019.61			Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5830	2,029.01			Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
L5840	2,971.03			Addition, endoskeletal knee-shin system, 4-bar linkage or multiaxial, pneumatic swing phase control
L5845	1,411.11			Addition, endoskeletal knee-shin system, stance flexion feature, adjustable
L5846	4,483.00			Addition, endoskeletal knee-shin system, microprocessor control feature, swing phase only
L5847	12,193.31			Addition, endoskeletal knee-shin system, microprocessor control feature, stance phase
L5848	846.60			Addition to endoskeletal, knee-shin system, hydraulic stance extension, dampening feature, with or without adjustability
L5850	102.59			Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist
L5855	247.67			Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist
L5910	387.27			Addition, endoskeletal system, below knee, alignable system
L5920	567.35			Addition, endoskeletal system, above knee or hip disarticulation, alignable system
L5925	269.47			Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock
L5930	2,783.69			Addition, endoskeletal system, high activity knee control frame
L5940	402.27			Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5950	783.41			Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
L5960	861.74			Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5962	471.39			Addition, endoskeletal system, below knee, flexible protective outer surface covering system
L5964	854.03			Addition, endoskeletal system, above knee, flexible protective outer surface covering system
L5966	1,100.12			Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system
L5968	2,860.96			Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature
L5970	217.17			All lower extremity prostheses, foot, external keel, SACH foot
L5972	329.47			All lower extremity prostheses, flexible keel foot (Safe, Sten, Bock Dynamic or equal)
L5974	243.63			All lower extremity prostheses, foot, single axis ankle/foot
L5975	364.98			All lower extremity prosthesis, combination single axis ankle and flexible keel foot
L5976	551.04			All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)
L5978	297.88			All lower extremity prostheses, foot, multi-axial ankle/foot
L5979	1,899.49			All lower extremity prostheses, multi-axial ankle, dynamic response foot, one piece system
L5980	3,490.61			All lower extremity prostheses, flex-foot system
L5981	2,599.59			All lower extremity prostheses, flex-walk system or equal
L5982	615.57			All exoskeletal lower extremity prostheses, axial rotation unit
L5984	555.17			All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability
L5985	233.52			All endoskeletal lower extremity prostheses, dynamic prosthetic pylon

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
L5986	520.22			All lower extremity prostheses, multi-axial rotation unit (MCP" or equal)"
L5987	5,663.55			All lower extremity prosthesis, shank foot system with vertical loading pylon
L5988	1,572.78			Addition to lower limb prosthesis, vertical shock reducing pylon feature
L5989	2,438.65			Addition to lower extremity prosthesis, endoskeletal system, pylon with integrated electronic force sensors
L5990	1,428.31			Addition to lower extremity prosthesis, user adjustable heel height
L5995	I.C.			Addition to lower extremity prosthesis, heavy duty feature (for patient weight > 300 lbs)
L6000	1,065.57			Partial hand, Robin-Aids, thumb remaining (or equal)
L6010	1,185.80			Partial hand, Robin-Aids, little and/or ring finger remaining (or equal)
L6020	1,105.57			Partial hand, Robin-Aids, no finger remaining (or equal)
L6025	6,300.21			Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device
L6050	1,687.74			Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad
L6055	2,664.40			Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad
L6100	1,698.31			Below elbow, molded socket, flexible elbow hinge, triceps pad
L6110	1,695.44			Below elbow, molded socket (Muenster or Northwestern suspension types)
L6120	2,142.54			Below elbow, molded double wall split socket, step-up hinges, half cuff
L6130	2,328.49			Below elbow, molded double wall split socket, stump activated locking hinge, half cuff
L6200	2,665.63			Elbow disarticulation, molded socket, outside locking hinge, forearm
L6205	3,695.18			Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm
L6250	2,209.38			Above elbow, molded double wall socket, internal locking elbow, forearm
L6300	3,981.36			Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6310	2,433.65			Shoulder disarticulation, passive restoration (complete prosthesis)
L6320	1,376.83			Shoulder disarticulation, passive restoration (shoulder cap only)
L6350	3,141.25			Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6360	2,554.41			Interscapular thoracic, passive restoration (complete prosthesis)
L6370	1,680.22			Interscapular thoracic, passive restoration (shoulder cap only)
L6380	940.90			Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, wrist disarticulation or below elbow
L6382	1,226.24			Immediate postsurgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, elbow disarticulation or above elbow
L6384	1,529.04			Immediate postsurgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic
L6386	362.70			Immediate postsurgical or early fitting, each additional cast change and realignment

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
L6388	470.08			Immediate postsurgical or early fitting, application of rigid dressing only
L6400	1,860.88			Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6450	3,238.09			Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6500	2,791.14			Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6550	3,282.33			Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6570	4,458.10			Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6580	1,300.85			Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC" or equal pylon
L6582	1,151.14			Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC" or equal pylon
L6584	1,903.87			Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC" or equal pylon
L6586	1,664.26			Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC" or equal pylon
L6588	2,799.14			Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC" or equal pylon
L6590	2,471.23			Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC" or equal pylon
L6600	150.43			Upper extremity additions, polycentric hinge, pair
L6605	148.53			Upper extremity additions, single pivot hinge, pair
L6610	133.52			Upper extremity additions, flexible metal hinge, pair
L6615	139.31			Upper extremity addition, disconnect locking wrist unit
L6616	57.56			Upper extremity addition, additional disconnect insert for locking wrist unit, each
L6620	258.34			Upper extremity addition, flexion/extension wrist unit, with or without friction
L6623	565.69			Upper extremity addition, spring assisted rotational wrist unit with latch release
L6625	568.71			Upper extremity addition, rotation wrist unit with cable lock
L6628	456.19			Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal
L6629	121.17			Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal
L6630	230.45			Upper extremity addition, stainless steel, any wrist
L6632	56.01			Upper extremity addition, latex suspension sleeve, each
L6635	144.51			Upper extremity addition, lift assist for elbow
L6637	392.63			Upper extremity addition, nudge control elbow lock
L6638	1,968.81			Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
L6640	224.64			Upper extremity additions, shoulder abduction joint, pair
L6641	152.48			Upper extremity addition, excursion amplifier, pulley type
L6642	213.29			Upper extremity addition, excursion amplifier, lever type
L6645	256.01			Upper extremity addition, shoulder flexion-abduction joint, each
L6646	2,483.11			Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system
L6647	408.79			Upper extremity addition, shoulder lock mechanism, body powered actuator
L6648	2,560.98			Upper extremity addition, shoulder lock mechanism, external powered actuator
L6650	296.02			Upper extremity addition, shoulder universal joint, each
L6655	65.92			Upper extremity addition, standard control cable, extra
L6660	93.38			Upper extremity addition, heavy duty control cable
L6665	44.91			Upper extremity addition, Teflon, or equal, cable lining
L6670	41.06			Upper extremity addition, hook to hand, cable adapter
L6672	135.22			Upper extremity addition, harness, chest or shoulder, saddle type
L6675	128.41			Upper extremity addition, harness, (e.g. figure of eight type), single cable design
L6676	101.74			Upper extremity addition, harness, (e.g. figure of eight type), dual cable design
L6680	189.33			Upper extremity addition, test socket, wrist disarticulation or below elbow
L6682	230.39			Upper extremity addition, test socket, elbow disarticulation or above elbow
L6684	344.57			Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic
L6686	631.27			Upper extremity addition, suction socket
L6687	462.58			Upper extremity addition, frame type socket, below elbow or wrist disarticulation
L6688	448.97			Upper extremity addition, frame type socket, above elbow or elbow disarticulation
L6689	552.19			Upper extremity addition, frame type socket, shoulder disarticulation
L6690	579.07			Upper extremity addition, frame type socket, interscapular-thoracic
L6691	369.11			Upper extremity addition, removable insert, each
L6692	499.41			Upper extremity addition, silicone gel insert or equal, each
L6693	2,235.13			Upper extremity addition, locking elbow, forearm counterbalance
L6700	416.01			Terminal device, hook, Dorrance or equal, model #3
L6705	256.87			Terminal device, hook, Dorrance or equal, model #5
L6710	327.45			Terminal device, hook, Dorrance or equal, model #5X
L6715	317.29			Terminal device, hook, Dorrance or equal, model #5XA
L6720	694.05			Terminal device, hook, Dorrance or equal, model #6
L6725	351.19			Terminal device, hook, Dorrance or equal, model #7
L6730	512.47			Terminal device, hook, Dorrance or equal, model #7LO
L6735	238.97			Terminal device, hook, Dorrance or equal, model #8
L6740	311.55			Terminal device, hook, Dorrance or equal, model #8X
L6745	300.58			Terminal device, hook, Dorrance or equal, model #88X

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
L6750	300.02			Terminal device, hook, Dorrance or equal, model #10P
L6755	301.12			Terminal device, hook, Dorrance or equal, model #10X
L6765	307.72			Terminal device, hook, Dorrance or equal, model #12P
L6770	307.72			Terminal device, hook, Dorrance or equal, model #99X
L6775	395.62			Terminal device, hook, Dorrance or equal, model #555
L6780	384.24			Terminal device, hook, Dorrance or equal, model #SS555
L6790	432.71			Terminal device, hook, Accu hook or equal
L6795	1,043.55			Terminal device, hook, 2 load or equal
L6800	812.57			Terminal device, hook, APRL VC or equal
L6805	290.01			Terminal device, modifier wrist flexion unit
L6806	1,273.30			Terminal device, hook, TRS Grip, Grip III, VC, or equal
L6807	1,409.05			Terminal device, hook, Grip I, Grip II, VC, or equal
L6808	1,070.27			Terminal device, hook, TRS Adept, infant or child, VC, or equal
L6809	317.67			Terminal device, hook, TRS Super Sport, passive
L6810	149.75			Terminal device, pincher tool, Otto Bock or equal
L6825	888.06			Terminal device, hand, Dorrance, VO
L6830	1,086.02			Terminal device, hand, APRL, VC
L6835	1,028.84			Terminal device, hand, Sierra, VO
L6840	657.52			Terminal device, hand, Becker Imperial
L6845	619.86			Terminal device, hand, Becker Lock Grip
L6850	609.15			Terminal device, hand, Becker Plylite
L6855	937.06			Terminal device, hand, Robin-Aids, VO
L6860	533.01			Terminal device, hand, Robin-Aids, VO soft
L6865	310.90			Terminal device, hand, passive hand
L6867	818.60			Terminal device, hand, Detroit Infant Hand (mechanical)
L6868	192.27			Terminal device, hand, passive infant hand, Steeper, Hosmer or equal
L6870	213.75			Terminal device, hand, child mitt
L6872	881.53			Terminal device, hand, NYU child hand
L6873	375.16			Terminal device, hand, mechanical infant hand, Steeper or equal
L6875	623.33			Terminal device, hand, Bock, VC
L6880	404.39			Terminal device, hand, Bock, VO
L6881	3,218.65			Automatic grasp feature, addition to upper limb prosthetic terminal device
L6882	2,441.49			Microprocessor control feature, addition to upper limb prosthetic terminal device
L6890	150.83			Terminal device, glove for above hands, production glove
L6895	597.08			Terminal device, glove for above hands, custom glove
L6900	1,211.34			Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
L6905	1,177.46			Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining
L6910	1,147.08			Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining
L6915	538.98			Hand restoration (shading and measurements included), replacement glove for above
L6920	6,116.62			Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6925	7,111.26			Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6930	5,963.63			Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6935	6,942.96			Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6940	7,611.75			Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6945	8,663.93			Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6950	8,003.00			Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6955	9,689.11			Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6960	10,679.98			Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6965	12,530.88			Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6970	13,413.13			Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6975	15,118.15			Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L7010	2,929.07			Electronic hand, Otto Bock, Steeper or equal, switch controlled
L7015	4,979.84			Electronic hand, System Teknik, Variety Village or equal, switch controlled
L7020	3,033.81			Electronic greifer, Otto Bock or equal, switch controlled
L7025	2,913.61			Electronic hand, Otto Bock or equal, myoelectronically controlled
L7030	4,884.14			Electronic hand, System Teknik, Variety Village or equal, myoelectronically controlled

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L7035	3,048.69			Electronic greifer, Otto Bock or equal, myoelectronically controlled
L7040	2,330.10			Prehensile actuator, Hosmer or equal, switch controlled
L7045	1,296.25			Electronic hook, child, Michigan or equal, switch controlled
L7170	4,748.03			Electronic elbow, Hosmer or equal, switch controlled
L7180	30,186.65			Electronic elbow, Boston, Utah or equal, myoelectronically controlled
L7185	4,945.64			Electronic elbow, adolescent, Variety Village or equal, switch controlled
L7186	7,804.77			Electronic elbow, child, Variety Village or equal, switch controlled
L7190	6,627.92			Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled
L7191	8,216.42			Electronic elbow, child, Variety Village or equal, myoelectronically controlled
L7260	2,096.39			Electronic wrist rotator, Otto Bock or equal
L7261	3,786.91			Electronic wrist rotator, for Utah arm
L7266	794.01			Servo control, Steeper or equal
L7272	1,765.50			Analogue control, UNB or equal
L7274	5,703.05			Proportional control, 6-12 volt, Liberty, Utah or equal
L7360	215.91			Six volt battery, Otto Bock or equal, each
L7362	223.14			Battery charger, six volt, Otto Bock or equal
L7364	403.78			Twelve volt battery, Utah or equal, each
L7366	549.69			Battery charger, twelve volt, Utah or equal
L7367	306.51			Lithium ion battery, replacement
L7368	397.34			Lithium ion battery charger
L7900	432.10			Male vacuum erection system
L8000	29.82			Breast prosthesis, mastectomy bra
L8001	98.74			Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral
L8002	129.88			Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral
L8015	47.19			External breast prosthesis garment, with mastectomy form, post-mastectomy
L8020	160.88			Breast prosthesis, mastectomy form
L8030	337.34			Breast prosthesis, silicone or equal
L8035	2,884.34			Custom breast prosthesis, post mastectomy, molded to patient model
L8040	2,107.03			Nasal prosthesis, provided by a non-physician
L8040	842.81			Nasal prosthesis, provided by a non-physician
L8040	2,001.68			Nasal prosthesis, provided by a non-physician
L8041	1,015.91			Midfacial prosthesis, provided by a non-physician
L8041	2,412.81			Midfacial prosthesis, provided by a non-physician
L8041	2,539.79			Midfacial prosthesis, provided by a non-physician
L8042	2,711.02			Orbital prosthesis, provided by a non-physician
L8042	1,141.48			Orbital prosthesis, provided by a non-physician

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
L8042	2,853.70			Orbital prosthesis, provided by a non-physician
L8043	3,036.35			Upper facial prosthesis, provided by a non-physician
L8043	1,278.45			Upper facial prosthesis, provided by a non-physician
L8043	3,196.15			Upper facial prosthesis, provided by a non-physician
L8044	3,538.58			Hemi-facial prosthesis, provided by a non-physician
L8044	1,415.43			Hemi-facial prosthesis, provided by a non-physician
L8044	3,361.65			Hemi-facial prosthesis, provided by a non-physician
L8045	2,113.38			Auricular prosthesis, provided by a non-physician
L8045	2,224.61			Auricular prosthesis, provided by a non-physician
L8045	889.84			Auricular prosthesis, provided by a non-physician
L8046	2,282.96			Partial facial prosthesis, provided by a non-physician
L8046	913.19			Partial facial prosthesis, provided by a non-physician
L8046	2,168.81			Partial facial prosthesis, provided by a non-physician
L8047	1,111.52			Nasal septal prosthesis, provided by a non-physician
L8047	1,170.02			Nasal septal prosthesis, provided by a non-physician
L8047	468.00			Nasal septal prosthesis, provided by a non-physician
L8110	43.27			Gradient compression stocking, below knee, 30-40 mmhg, each
L8120	60.96			Gradient compression stocking, below knee, 40-50 mmhg, each
L8300	67.65			Truss, single with standard pad
L8310	106.80			Truss, double with standard pads
L8320	56.79			Truss, addition to standard pad, water pad
L8330	52.79			Truss, addition to standard pad, scrotal pad
L8400	14.37			Prosthetic sheath, below knee, each
L8410	22.15			Prosthetic sheath, above knee, each
L8415	22.92			Prosthetic sheath, upper limb, each
L8417	59.12			Prosthetic sheath/sock, including a gel cushion layer, below knee or above knee, each
L8420	16.68			Prosthetic sock, multiple ply, below knee, each
L8430	19.51			Prosthetic sock, multiple ply, above knee, each
L8435	21.76			Prosthetic sock, multiple ply, upper limb, each
L8440	37.72			Prosthetic shrinker, below knee, each
L8460	61.50			Prosthetic shrinker, above knee, each
L8465	41.10			Prosthetic shrinker, upper limb, each
L8470	5.35			Prosthetic sock, single ply, fitting, below knee, each
L8480	9.36			Prosthetic sock, single ply, fitting, above knee, each
L8485	9.38			Prosthetic sock, single ply, fitting, upper limb, each
L8490	133.77			Addition to prosthetic sheath/sock, air seal suction retention system

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
L8500	595.90			Artificial larynx, any type
L8501	129.17			Tracheostomy speaking valve
L8507	32.98			Tracheo-esophageal voice prosthesis, patient inserted, any type, each
L8509	85.98			Tracheo-esophageal voice prosthesis, inserted by a licensed health care provider, any type
L8510	198.94			Voice amplifier
L8511	57.26			Insert for indwelling tracheoesophageal prosthesis, with or without valve, replacement only, each
L8512	1.70			Gelatin capsules or equivalent, for use with tracheoesophageal voice prosthesis, replacement only, per 10
L8513	4.08			Cleaning device used with tracheoesophageal voice prosthesis, pipet, brush, or equal, replacement only, each
L8514	74.24			Tracheoesophageal puncture dilator, replacement only, each
L8600	505.14			Implantable breast prosthesis, silicone or equal
L8603	351.17			Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies
L8606	172.59			Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies
L8610	469.40			Ocular implant
L8612	575.41			Aqueous shunt
L8613	250.55			Ossicular implant
L8614	15,354.57			Cochlear device/system
L8619	6,591.62			Cochlear implant external speech processor, replacement
L8630	360.25			Metacarpophalangeal joint implant
L8631	1,756.79			Metacarpal phalangeal joint replacement, two or more pieces, metal (e.g., stainless steel or cobalt chrome), ceramic-like material (e.g., pyrocarbon), for surgical implantation (all sizes, includes entire system)
L8641	374.30			Metatarsal joint implant
L8642	227.70			Hallux implant
L8658	326.35			Interphalangeal joint spacer, silicone or equal, each
L8659	1,519.23			Interphalangeal finger joint replacement, two or more pieces, metal (e.g., stainless steel or cobalt chrome), ceramic-like material (e.g., pyrocarbon) for surgical implantation, any size
L8670	446.41			Vascular graft material, synthetic, implant
V2020	56.84			Frames, purchases
V2100	31.41			Sphere, single vision, plano to plus or minus 4.00, per lens
V2101	33.10			Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens
V2102	46.57			Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens
V2103	27.28			Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
V2104	30.21			Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens
V2105	32.89			Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder,

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
				per lens
V2106	39.21			Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
V2107	34.71			Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00d cylinder, per lens
V2108	35.94			Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
V2109	39.76			Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
V2110	40.01			Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens
V2111	40.90			Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2112	44.65			Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens
V2113	51.60			Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2114	54.51			Spherocylinder, single vision sphere over plus or minus 12.00d, per lens
V2115	59.33			Lenticular (myodisc), per lens, single vision
V2116	63.95			Lenticular lens, nonaspheric, per lens, single vision
V2117	68.78			Lenticular, aspheric, per lens, single vision
V2118	78.41			Aniseikonic lens, single vision
V2121	68.44			Lenticular lens, per lens, single
V2200	44.34			Sphere, bifocal, plano to plus or minus 4.00d, per lens
V2201	47.41			Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens
V2202	54.06			Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens
V2203	44.04			Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
V2204	46.49			Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens
V2205	49.43			Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens
V2206	51.58			Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
V2207	50.00			Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens
V2208	50.95			Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
V2209	57.73			Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
V2210	57.78			Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens
V2211	64.77			Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2212	70.48			Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
				cylinder, per lens
V2213	67.93			Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2214	67.15			Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens
V2215	68.17			Lenticular (myodisc), per lens, bifocal
V2216	98.43			Lenticular, nonaspheric, per lens, bifocal
V2217	80.14			Lenticular, aspheric lens, bifocal
V2218	108.16			Aniseikonic, per lens, bifocal
V2219	35.71			Bifocal seg width over 28mm
V2220	28.96			Bifocal add over 3.25d
V2221	85.24			Lenticular lens, per lens, bifocal
V2300	58.01			Sphere, trifocal, plano to plus or minus 4.00d, per lens
V2301	78.85			Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d per lens
V2302	87.69			Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens
V2303	58.48			Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
V2304	60.01			Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25 to 4.00d cylinder, per lens
V2305	74.76			Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00 cylinder, per lens
V2306	72.37			Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
V2307	78.80			Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens
V2308	81.16			Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
V2309	92.66			Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
V2310	78.46			Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens
V2311	90.11			Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2312	95.82			Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens
V2313	103.63			Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2314	86.19			Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens
V2315	127.59			Lenticular (myodisc), per lens, trifocal
V2316	119.62			Lenticular nonaspheric, per lens, trifocal
V2317	128.74			Lenticular, aspheric lens, trifocal
V2318	156.85			Aniseikonic lens, trifocal
V2319	42.67			Trifocal seg width over 28 mm

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
V2320	42.02			Trifocal add over 3.25d
V2321	125.76			Lenticular lens, per lens, trifocal
V2410	71.91			Variable asphericity lens, single vision, full field, glass or plastic, per lens
V2430	88.39			Variable asphericity lens, bifocal, full field, glass or plastic, per lens
V2500	68.36			Contact lens, PMMA, spherical, per lens
V2501	132.39			Contact lens, PMMA, toric or prism ballast, per lens
V2502	160.57			Contact lens, PMMA, bifocal, per lens
V2503	150.20			Contact lens, PMMA, color vision deficiency, per lens
V2510	101.58			Contact lens, gas permeable, spherical, per lens
V2511	170.47			Contact lens, gas permeable, toric, prism ballast, per lens
V2512	178.63			Contact lens, gas permeable, bifocal, per lens
V2513	144.74			Contact lens, gas permeable, extended wear, per lens
V2520	98.45			Contact lens, hydrophilic, spherical, per lens
V2521	151.24			Contact lens, hydrophilic, toric, or prism ballast, per lens
V2522	185.68			Contact lens, hydrophilic, bifocal, per lens
V2523	156.04			Contact lens, hydrophilic, extended wear, per lens
V2530	238.49			Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see CPT Level I code 92325)
V2531	447.81			Contact lens, scleral, gas permeable, per lens (for contact lens modification, see CPT Level I code 92325)
V2623	758.67			Prosthetic eye, plastic, custom
V2624	48.82			Polishing/resurfacing of ocular prosthesis
V2625	296.82			Enlargement of ocular prosthesis
V2626	160.00			Reduction of ocular prosthesis
V2627	1,033.36			Scleral cover shell
V2628	244.00			Fabrication and fitting of ocular conformer
V2700	36.82			Balance lens, per lens
V2710	51.42			Slab off prism, glass or plastic, per lens
V2715	9.32			Prism, per lens
V2718	29.60			Press-on lens, Fresnell prism, per lens
V2730	17.33			Special base curve, glass or plastic, per lens
V2740	8.41			Tint, plastic, rose 1 or 2, per lens
V2741	8.07			Tint, plastic, other than rose 1 or 2, per lens
V2742	8.03			Tint, glass, rose 1 or 2, per lens
V2743	10.27			Tint, glass, other than rose 1 or 2, per lens
V2744	13.16			Tint, photochromatic, per lens
V2745	8.24			Addition to lens, tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens

Code	Fee New NU	Fee Used UE	Fee Rental RR	114.3 CMR 40.06(6) - DMEPOS Description
V2750	15.31			Antireflective coating, per lens
V2755	17.76			U-V lens, per lens
V2760	13.53			Scratch resistant coating, per lens
V2762	46.92			Polarization, any lens material, per lens
V2770	20.87			Occluder lens, per lens
V2780	10.99			Oversize lens, per lens
V2782	50.68			Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens
V2783	57.14			Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens
V2784	37.16			Lens, polycarbonate or equal, any index, per lens
V2786	I.C.			Specialty occupational multifocal lens, per lens

40.06(7) Freestanding Diagnostic Facilities / Radiology

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
70010	252.95	63.41	189.54	Myelography, posterior fossa, radiological supervision and interpretation
70015	122.84	63.11	59.73	Cisternography, positive contrast, radiological supervision and interpretation
70030	27.12	9.24	17.88	Radiologic examination, eye, for detection of foreign body
70100	32.14	9.62	22.52	Radiologic examination, mandible; partial, less than four views
70110	40.43	13.10	27.33	Radiologic examination, mandible; complete, minimum of four views
70120	36.95	9.62	27.33	Radiologic examination, mastoids; less than three views per side
70130	52.56	17.76	34.80	Radiologic examination, mastoids; complete, minimum of three views per side
70134	50.45	17.76	32.69	Radiologic examination, internal auditory meati, complete
70140	37.32	9.99	27.33	Radiologic examination, facial bones; less than three views
70150	48.70	13.90	34.80	Radiologic examination, facial bones; complete, minimum of three views
70160	31.76	9.24	22.52	Radiologic examination, nasal bones, complete, minimum of three views
70170	57.68	15.83	41.85	Dacryocystography, nasolacrimal duct, radiological supervision and interpretation
70190	38.50	11.17	27.33	Radiologic examination; optic foramina
70200	49.45	14.65	34.80	Radiologic examination; orbits, complete, minimum of four views
70210	36.57	9.24	27.33	Radiologic examination, sinuses, paranasal, less than three views
70220	47.90	13.10	34.80	Radiologic examination, sinuses, paranasal, complete, minimum of three views
70240	27.87	9.99	17.88	Radiologic examination, sella turcica
70250	40.05	12.72	27.33	Radiologic examination, skull; less than four views
70260	57.08	17.76	39.32	Radiologic examination, skull; complete, minimum of four views
70300	18.16	6.18	11.98	Radiologic examination, teeth; single view
70310	27.59	9.71	17.88	Radiologic examination, teeth; partial examination, less than full mouth
70320	46.77	11.97	34.80	Radiologic examination, teeth; complete, full mouth
70328	30.88	9.62	21.26	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral
70330	50.05	12.72	37.33	Radiologic examination, temporomandibular joint, open and closed mouth; bilateral
70332	121.51	29.39	92.12	Temporomandibular joint arthrography, radiological supervision and interpretation
70336	569.94	78.44	491.50	Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)
70350	25.86	9.66	16.20	Cephalogram, orthodontic
70355	36.44	11.21	25.23	Orthopantogram
70360	27.12	9.24	17.88	Radiologic examination; neck, soft tissue
70370	74.32	17.00	57.32	Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification technique
70371	137.10	44.98	92.12	Complex dynamic pharyngeal and speech evaluation by cine or video recording
70373	102.27	23.52	78.75	Laryngography, contrast, radiological supervision and interpretation
70380	38.68	9.24	29.44	Radiologic examination, salivary gland for calculus
70390	99.16	20.41	78.75	Sialography, radiological supervision and interpretation
70450	252.67	45.36	207.31	Computed tomography, head or brain; without contrast material
70460	308.02	60.01	248.01	Computed tomography, head or brain; with contrast material(s)
70470	377.66	67.27	310.39	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
70480	275.38	68.07	207.31	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
70481	321.12	73.11	248.01	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)
70482	386.98	76.59	310.39	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections
70486	267.70	60.39	207.31	Computed tomography, maxillofacial area; without contrast material
70487	316.84	68.83	248.01	Computed tomography, maxillofacial area; with contrast material(s)
70488	385.43	75.04	310.39	Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections
70490	275.38	68.07	207.31	Computed tomography, soft tissue neck; without contrast material
70491	321.12	73.11	248.01	Computed tomography, soft tissue neck; with contrast material(s)
70492	386.98	76.59	310.39	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections
70496	559.35	93.02	466.33	Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
70498	559.35	93.02	466.33	Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
70540	556.46	70.96	485.50	Magnetic resonance (eg, proton) imaging, orbit, face, and neck; without contrast material(s)
70542	667.98	85.23	582.75	Magnetic resonance (eg, proton) imaging, orbit, face, and neck; with contrast material(s)
70543	1,191.60	113.41	1,078.19	Magnetic resonance (eg, proton) imaging, orbit, face, and neck; without contrast material(s), followed by contrast material(s) and further sequences
70544	554.99	63.49	491.50	Magnetic resonance angiography, head; without contrast material(s)
70545	554.99	63.49	491.50	Magnetic resonance angiography, head; with contrast material(s)
70546	1,061.48	95.75	965.73	Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences
70547	554.99	63.49	491.50	Magnetic resonance angiography, neck; without contrast material(s)
70548	554.99	63.49	491.50	Magnetic resonance angiography, neck; with contrast material(s)
70549	1,061.48	95.75	965.73	Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences
70551	570.37	78.87	491.50	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material
70552	684.63	94.99	589.64	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)
70553	1,217.76	125.48	1,092.28	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
70557	153.07	153.07		Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material
70558	169.20	169.20		Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); with contrast material(s)
70559	169.80	169.80		Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material(s), followed by contrast material(s) and further sequences
71010	30.03	9.62	20.41	Radiologic examination, chest; single view, frontal
71015	33.69	11.17	22.52	Radiologic examination, chest; stereo, frontal

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
71020	38.88	11.55	27.33	Radiologic examination, chest, two views, frontal and lateral;
71021	46.97	14.28	32.69	Radiologic examination, chest, two views, frontal and lateral; with apical lordotic procedure
71022	49.20	16.51	32.69	Radiologic examination, chest, two views, frontal and lateral; with oblique projections
71023	55.21	20.41	34.80	Radiologic examination, chest, two views, frontal and lateral; with fluoroscopy
71030	51.01	16.21	34.80	Radiologic examination, chest, complete, minimum of four views;
71034	87.79	24.69	63.10	Radiologic examination, chest, complete, minimum of four views; with fluoroscopy
71035	32.14	9.62	22.52	Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies)
71040	95.02	31.08	63.94	Bronchography, unilateral, radiological supervision and interpretation
71060	136.70	39.64	97.06	Bronchography, bilateral, radiological supervision and interpretation
71090	104.36	29.82	74.54	Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation
71100	36.78	11.55	25.23	Radiologic examination, ribs, unilateral; two views
71101	43.72	14.28	29.44	Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of three views
71110	49.08	14.28	34.80	Radiologic examination, ribs, bilateral; three views
71111	56.32	17.00	39.32	Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of four views
71120	39.39	10.79	28.60	Radiologic examination; sternum, minimum of two views
71130	42.68	11.55	31.13	Radiologic examination; sternoclavicular joint or joints, minimum of three views
71250	320.83	61.56	259.27	Computed tomography, thorax; without contrast material
71260	375.81	65.42	310.39	Computed tomography, thorax; with contrast material(s)
71270	461.23	73.11	388.12	Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections
71275	636.30	101.06	535.24	Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
71550	564.09	76.79	487.30	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)
71551	675.62	91.37	584.25	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)
71552	1,192.81	119.42	1,073.39	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences
71555	588.05	96.55	491.50	Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)
72010	69.71	24.49	45.22	Radiologic examination, spine, entire, survey study, anteroposterior and lateral
72020	25.94	8.06	17.88	Radiologic examination, spine, single view, specify level
72040	38.04	11.55	26.49	Radiologic examination, spine, cervical; two or three views
72050	55.83	16.51	39.32	Radiologic examination, spine, cervical; minimum of four views
72052	68.66	19.23	49.43	Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies
72069	33.53	12.27	21.26	Radiologic examination, spine, thoracolumbar, standing (scoliosis)
72070	40.15	11.55	28.60	Radiologic examination, spine; thoracic, two views
72072	44.24	11.55	32.69	Radiologic examination, spine; thoracic, three views
72074	51.71	11.55	40.16	Radiologic examination, spine; thoracic, minimum of four views

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72080	41.29	11.85	29.44	Radiologic examination, spine; thoracolumbar, two views
72090	44.39	14.95	29.44	Radiologic examination, spine; scoliosis study, including supine and erect studies
72100	41.29	11.85	29.44	Radiologic examination, spine, lumbosacral; two or three views
72110	56.67	16.51	40.16	Radiologic examination, spine, lumbosacral; minimum of four views
72114	71.79	19.83	51.96	Radiologic examination, spine, lumbosacral; complete, including bending views
72120	51.17	11.85	39.32	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views
72125	320.83	61.56	259.27	Computed tomography, cervical spine; without contrast material
72126	374.64	64.25	310.39	Computed tomography, cervical spine; with contrast material
72127	455.39	67.27	388.12	Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections
72128	320.83	61.56	259.27	Computed tomography, thoracic spine; without contrast material
72129	374.64	64.25	310.39	Computed tomography, thoracic spine; with contrast material
72130	455.39	67.27	388.12	Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections
72131	320.83	61.56	259.27	Computed tomography, lumbar spine; without contrast material
72132	375.36	64.97	310.39	Computed tomography, lumbar spine; with contrast material
72133	455.82	67.70	388.12	Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections
72141	576.58	85.08	491.50	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
72142	692.74	103.10	589.64	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)
72146	629.93	84.66	545.27	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
72147	692.32	102.68	589.64	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)
72148	624.14	78.87	545.27	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72149	685.36	95.72	589.64	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)
72156	1,228.93	136.65	1,092.28	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical
72157	1,228.93	136.65	1,092.28	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic
72158	1,218.06	125.78	1,092.28	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
72159	634.69	99.96	534.73	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)
72170	31.76	9.24	22.52	Radiologic examination, pelvis; one or two views
72190	40.61	11.17	29.44	Radiologic examination, pelvis; complete, minimum of three views
72191	616.14	95.65	520.49	Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
72192	317.35	58.08	259.27	Computed tomography, pelvis; without contrast material
72193	361.95	61.56	300.39	Computed tomography, pelvis; with contrast material(s)
72194	436.71	64.67	372.04	Computed tomography, pelvis; without contrast material, followed by contrast

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				material(s) and further sections
72195	564.39	77.09	487.30	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)
72196	675.32	91.07	584.25	Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)
72197	1,200.01	119.42	1,080.59	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences
72198	591.04	99.54	491.50	Magnetic resonance angiography, pelvis, with or without contrast material(s)
72200	31.76	9.24	22.52	Radiologic examination, sacroiliac joints; less than three views
72202	37.32	9.99	27.33	Radiologic examination, sacroiliac joints; three or more views
72220	34.47	9.24	25.23	Radiologic examination, sacrum and coccyx, minimum of two views
72240	256.61	48.04	208.57	Myelography, cervical, radiological supervision and interpretation
72255	237.16	47.62	189.54	Myelography, thoracic, radiological supervision and interpretation
72265	222.77	43.76	179.01	Myelography, lumbosacral, radiological supervision and interpretation
72270	337.72	69.84	267.88	Myelography, two or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation
72275	133.41	38.29	95.12	Epidurography, radiological supervision and interpretation
72285	428.43	61.02	367.41	Diskography, cervical or thoracic, radiological supervision and interpretation
72295	388.35	44.18	344.17	Diskography, lumbar, radiological supervision and interpretation
73000	30.96	8.44	22.52	Radiologic examination; clavicle, complete
73010	31.76	9.24	22.52	Radiologic examination; scapula, complete
73020	28.47	8.06	20.41	Radiologic examination, shoulder; one view
73030	34.85	9.62	25.23	Radiologic examination, shoulder; complete, minimum of two views
73040	121.27	29.15	92.12	Radiologic examination, shoulder, arthrography, radiological supervision and interpretation
73050	40.53	11.09	29.44	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction
73060	34.47	9.24	25.23	Radiologic examination; humerus, minimum of two views
73070	30.58	8.06	22.52	Radiologic examination, elbow; two views
73080	34.47	9.24	25.23	Radiologic examination, elbow; complete, minimum of three views
73085	121.69	29.57	92.12	Radiologic examination, elbow, arthrography, radiological supervision and interpretation
73090	30.96	8.44	22.52	Radiologic examination; forearm, two views
73092	29.70	8.44	21.26	Radiologic examination; upper extremity, infant, minimum of two views
73100	30.42	9.16	21.26	Radiologic examination, wrist; two views
73110	32.18	9.24	22.94	Radiologic examination, wrist; complete, minimum of three views
73115	99.17	29.57	69.60	Radiologic examination, wrist, arthrography, radiological supervision and interpretation
73120	29.70	8.44	21.26	Radiologic examination, hand; two views
73130	32.18	9.24	22.94	Radiologic examination, hand; minimum of three views
73140	24.77	6.89	17.88	Radiologic examination, finger(s), minimum of two views
73200	275.08	58.08	217.00	Computed tomography, upper extremity; without contrast material
73201	320.83	61.56	259.27	Computed tomography, upper extremity; with contrast material(s)
73202	390.71	64.97	325.74	Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections
73206	570.62	95.23	475.39	Computed tomographic angiography, upper extremity, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
73218	556.46	70.96	485.50	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without

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				contrast material(s)
73219	667.98	85.23	582.75	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s)
73220	1,192.20	114.01	1,078.19	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences
73221	556.46	70.96	485.50	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
73222	667.98	85.23	582.75	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)
73223	1,191.60	113.41	1,078.19	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences
73225	578.28	96.48	481.80	Magnetic resonance angiography, upper extremity, with or without contrast material(s)
73500	29.65	9.24	20.41	Radiologic examination, hip, unilateral; one view
73510	36.70	11.47	25.23	Radiologic examination, hip, unilateral; complete, minimum of two views
73520	43.64	14.20	29.44	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis
73525	121.27	29.15	92.12	Radiologic examination, hip, arthrography, radiological supervision and interpretation
73530	37.97	15.45	22.52	Radiologic examination, hip, during operative procedure
73540	36.32	11.09	25.23	Radiologic examination, pelvis and hips, infant or child, minimum of two views
73542	122.31	30.19	92.12	Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation
73550	34.47	9.24	25.23	Radiologic examination, femur, two views
73560	32.06	9.54	22.52	Radiologic examination, knee; one or two views
73562	35.15	9.92	25.23	Radiologic examination, knee; three views
73564	39.60	12.27	27.33	Radiologic examination, knee; complete, four or more views
73565	30.80	9.54	21.26	Radiologic examination, knee; both knees, standing, anteroposterior
73580	143.79	29.15	114.64	Radiologic examination, knee, arthrography, radiological supervision and interpretation
73590	31.76	9.24	22.52	Radiologic examination; tibia and fibula, two views
73592	30.12	8.86	21.26	Radiologic examination; lower extremity, infant, minimum of two views
73600	29.70	8.44	21.26	Radiologic examination, ankle; two views
73610	32.18	9.24	22.94	Radiologic examination, ankle; complete, minimum of three views
73615	121.69	29.57	92.12	Radiologic examination, ankle, arthrography, radiological supervision and interpretation
73620	29.70	8.44	21.26	Radiologic examination, foot; two views
73630	32.18	9.24	22.94	Radiologic examination, foot; complete, minimum of three views
73650	28.85	8.44	20.41	Radiologic examination; calcaneus, minimum of two views
73660	24.77	6.89	17.88	Radiologic examination; toe(s), minimum of two views
73700	275.08	58.08	217.00	Computed tomography, lower extremity; without contrast material
73701	320.83	61.56	259.27	Computed tomography, lower extremity; with contrast material(s)
73702	390.41	64.67	325.74	Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections
73706	575.27	99.88	475.39	Computed tomographic angiography, lower extremity, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
73718	556.46	70.96	485.50	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)
73719	667.98	85.23	582.75	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast

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				material(s)
73720	1,192.20	114.01	1,078.19	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences
73721	556.46	70.96	485.50	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
73722	668.28	85.53	582.75	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s)
73723	1,191.60	113.41	1,078.19	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences
73725	588.42	96.92	491.50	Magnetic resonance angiography, lower extremity, with or without contrast material(s)
74000	32.14	9.62	22.52	Radiologic examination, abdomen; single anteroposterior view
74010	37.58	12.35	25.23	Radiologic examination, abdomen; anteroposterior and additional oblique and cone views
74020	41.61	14.28	27.33	Radiologic examination, abdomen; complete, including decubitus and/or erect views
74022	49.69	17.00	32.69	Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest
74150	311.12	63.11	248.01	Computed tomography, abdomen; without contrast material
74160	367.66	67.27	300.39	Computed tomography, abdomen; with contrast material(s)
74170	445.90	73.86	372.04	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections
74175	620.37	99.88	520.49	Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
74181	564.69	77.39	487.30	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)
74182	675.19	90.94	584.25	Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)
74183	1,200.01	119.42	1,080.59	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences
74185	587.25	95.75	491.50	Magnetic resonance angiography, abdomen, with or without contrast material(s)
74190	82.77	25.45	57.32	Peritoneogram (eg, after injection of air or contrast), radiological supervision and interpretation
74210	71.19	19.23	51.96	Radiologic examination; pharynx and/or cervical esophagus
74220	76.23	24.27	51.96	Radiologic examination; esophagus
74230	85.49	28.17	57.32	Swallowing function, with cineradiography/videoradiography
74235	177.75	63.11	114.64	Removal of foreign body(s), esophageal, with use of balloon catheter, radiological supervision and interpretation
74240	100.86	36.92	63.94	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB
74241	102.13	36.92	65.21	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, with KUB
74245	153.11	48.46	104.65	Radiologic examination, gastrointestinal tract, upper; with small intestine, includes multiple serial films
74246	109.47	36.92	72.55	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, without KUB
74247	111.46	36.92	74.54	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, with KUB
74249	161.84	48.46	113.38	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high

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				density barium, effervescent agent, with or without glucagon; with small intestine follow-through
74250	82.39	25.07	57.32	Radiologic examination, small intestine, includes multiple serial films;
74251	94.24	36.92	57.32	Radiologic examination, small intestine, includes multiple serial films; via enteroclysis tube
74260	91.83	26.62	65.21	Duodenography, hypotonic
74270	112.30	36.92	75.38	Radiologic examination, colon; barium enema, with or without KUB
74280	151.06	52.74	98.32	Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon
74283	220.25	107.30	112.95	Therapeutic enema, contrast or air, for reduction of intussusception or other intraluminal obstruction (eg, meconium ileus)
74290	49.69	17.00	32.69	Cholecystography, oral contrast;
74291	28.67	10.79	17.88	Cholecystography, oral contrast; additional or repeat examination or multiple day examination
74300	19.23	19.23		Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation
74301	11.17	11.17		Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)
74305	57.14	22.34	34.80	Cholangiography and/or pancreatography; through existing catheter, radiological supervision and interpretation
74320	167.27	28.55	138.72	Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation
74327	115.20	37.29	77.91	Postoperative biliary duct calculus removal, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique), radiological supervision and interpretation
74328	176.01	37.29	138.72	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation
74329	176.01	37.29	138.72	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation
74330	186.80	48.08	138.72	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation
74340	143.19	28.55	114.64	Introduction of long gastrointestinal tube (eg, Miller-Abbott), including multiple fluoroscopies and films, radiological supervision and interpretation
74350	179.12	40.40	138.72	Percutaneous placement of gastrostomy tube, radiological supervision and interpretation
74355	155.04	40.40	114.64	Percutaneous placement of enteroclysis tube, radiological supervision and interpretation
74360	167.69	28.97	138.72	Intraluminal dilation of strictures and/or obstructions (eg, esophagus), radiological supervision and interpretation
74363	314.79	46.91	267.88	Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation
74400	100.36	25.82	74.54	Urography (pyelography), intravenous, with or without KUB, with or without tomography
74410	111.74	25.82	85.92	Urography, infusion, drip technique and/or bolus technique;
74415	118.78	25.82	92.96	Urography, infusion, drip technique and/or bolus technique; with nephrotomography
74420	133.87	19.23	114.64	Urography, retrograde, with or without KUB
74425	76.55	19.23	57.32	Urography, antegrade, (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation
74430	63.78	17.30	46.48	Cystography, minimum of three views, radiological supervision and interpretation
74440	69.42	19.99	49.43	Vasography, vesiculography, or epididymography, radiological supervision and interpretation

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74445	109.82	60.39	49.43	Corpora cavernosography, radiological supervision and interpretation
74450	81.62	17.68	63.94	Urethrocystography, retrograde, radiological supervision and interpretation
74455	87.28	17.68	69.60	Urethrocystography, voiding, radiological supervision and interpretation
74470	83.34	28.55	54.79	Radiologic examination, renal cyst study, translumbar, contrast visualization, radiological supervision and interpretation
74475	207.56	28.55	179.01	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation
74480	207.56	28.55	179.01	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation
74485	167.87	29.15	138.72	Dilation of nephrostomy, ureters, or urethra, radiological supervision and interpretation
74710	64.54	18.06	46.48	Pelvimetry, with or without placental localization
74740	77.73	20.41	57.32	Hysterosalpingography, radiological supervision and interpretation
74742	170.75	32.03	138.72	Transcervical catheterization of fallopian tube, radiological supervision and interpretation
74775	97.37	33.43	63.94	Perineogram (eg, vaginogram, for sex determination or extent of anomalies)
75552	576.58	85.08	491.50	Cardiac magnetic resonance imaging for morphology; without contrast material
75553	597.62	106.12	491.50	Cardiac magnetic resonance imaging for morphology; with contrast material
75554	589.89	98.39	491.50	Cardiac magnetic resonance imaging for function, with or without morphology; complete study
75555	586.49	94.99	491.50	Cardiac magnetic resonance imaging for function, with or without morphology; limited study
75556	I.C.			Cardiac magnetic resonance imaging for velocity flow mapping
75600	579.40	27.09	552.31	Aortography, thoracic, without serialography, radiological supervision and interpretation
75605	613.54	61.23	552.31	Aortography, thoracic, by serialography, radiological supervision and interpretation
75625	613.12	60.81	552.31	Aortography, abdominal, by serialography, radiological supervision and interpretation
75630	672.06	96.21	575.85	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation
75635	812.42	127.53	684.89	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, radiological supervision and interpretation, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
75650	631.55	79.24	552.31	Angiography, cervicocerebral, catheter, including vessel origin, radiological supervision and interpretation
75658	623.62	71.31	552.31	Angiography, brachial, retrograde, radiological supervision and interpretation
75660	622.36	70.05	552.31	Angiography, external carotid, unilateral, selective, radiological supervision and interpretation
75662	642.78	90.47	552.31	Angiography, external carotid, bilateral, selective, radiological supervision and interpretation
75665	622.24	69.93	552.31	Angiography, carotid, cerebral, unilateral, radiological supervision and interpretation
75671	641.09	88.78	552.31	Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation
75676	622.66	70.35	552.31	Angiography, carotid, cervical, unilateral, radiological supervision and interpretation
75680	641.09	88.78	552.31	Angiography, carotid, cervical, bilateral, radiological supervision and interpretation
75685	621.94	69.63	552.31	Angiography, vertebral, cervical, and/or intracranial, radiological supervision and interpretation
75705	669.19	116.88	552.31	Angiography, spinal, selective, radiological supervision and interpretation
75710	613.42	61.11	552.31	Angiography, extremity, unilateral, radiological supervision and interpretation

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75716	621.94	69.63	552.31	Angiography, extremity, bilateral, radiological supervision and interpretation
75722	613.96	61.65	552.31	Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation
75724	633.90	81.59	552.31	Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation
75726	612.70	60.39	552.31	Angiography, visceral, selective or supraselective, (with or without flush aortogram), radiological supervision and interpretation
75731	612.70	60.39	552.31	Angiography, adrenal, unilateral, selective, radiological supervision and interpretation
75733	621.94	69.63	552.31	Angiography, adrenal, bilateral, selective, radiological supervision and interpretation
75736	612.70	60.39	552.31	Angiography, pelvic, selective or supraselective, radiological supervision and interpretation
75741	621.94	69.63	552.31	Angiography, pulmonary, unilateral, selective, radiological supervision and interpretation
75743	640.07	87.76	552.31	Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation
75746	612.70	60.39	552.31	Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation
75756	615.35	63.04	552.31	Angiography, internal mammary, radiological supervision and interpretation
75774	571.97	19.66	552.31	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)
75790	157.71	97.98	59.73	Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation
75801	281.74	43.73	238.01	Lymphangiography, extremity only, unilateral, radiological supervision and interpretation
75803	299.95	61.94	238.01	Lymphangiography, extremity only, bilateral, radiological supervision and interpretation
75805	311.31	43.43	267.88	Lymphangiography, pelvic/abdominal, unilateral, radiological supervision and interpretation
75807	329.82	61.94	267.88	Lymphangiography, pelvic/abdominal, bilateral, radiological supervision and interpretation
75809	59.87	25.07	34.80	Shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation
75810	613.00	60.69	552.31	Splenoportography, radiological supervision and interpretation
75820	79.14	37.29	41.85	Venography, extremity, unilateral, radiological supervision and interpretation
75822	121.32	56.53	64.79	Venography, extremity, bilateral, radiological supervision and interpretation
75825	613.00	60.69	552.31	Venography, caval, inferior, with serialography, radiological supervision and interpretation
75827	612.70	60.39	552.31	Venography, caval, superior, with serialography, radiological supervision and interpretation
75831	612.70	60.39	552.31	Venography, renal, unilateral, selective, radiological supervision and interpretation
75833	631.55	79.24	552.31	Venography, renal, bilateral, selective, radiological supervision and interpretation
75840	613.30	60.99	552.31	Venography, adrenal, unilateral, selective, radiological supervision and interpretation
75842	631.13	78.82	552.31	Venography, adrenal, bilateral, selective, radiological supervision and interpretation
75860	613.84	61.53	552.31	Venography, venous sinus (eg, petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation
75870	613.84	61.53	552.31	Venography, superior sagittal sinus, radiological supervision and interpretation

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
75872	612.70	60.39	552.31	Venography, epidural, radiological supervision and interpretation
75880	79.14	37.29	41.85	Venography, orbital, radiological supervision and interpretation
75885	628.52	76.21	552.31	Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation
75887	628.52	76.21	552.31	Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation
75889	612.70	60.39	552.31	Hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation
75891	612.70	60.39	552.31	Hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation
75893	580.86	28.55	552.31	Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation
75894	1,128.98	69.93	1,059.05	Transcatheter therapy, embolization, any method, radiological supervision and interpretation
75896	991.21	70.47	920.74	Transcatheter therapy, infusion, any method (eg, thrombolysis other than coronary), radiological supervision and interpretation
75898	134.29	87.81	46.48	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion
75900	946.02	25.82	920.20	Exchange of a previously placed arterial catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation
75901	105.93	25.82	80.11	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation
75902	100.90	20.79	80.11	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation
75940	581.46	29.15	552.31	Percutaneous placement of IVC filter, radiological supervision and interpretation
75945	222.45	22.19	200.26	Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel
75946	123.04	22.19	100.85	Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)
75952	257.14	257.14	I.C.	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation
75953	94.84	94.84		Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation
75954	129.25	129.25	I.C.	Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, radiological supervision and interpretation
75960	697.94	44.65	653.29	Transcatheter introduction of intravascular stent(s), (non-coronary vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel
75961	686.30	225.51	460.79	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation
75962	720.49	29.57	690.92	Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation
75964	387.06	19.23	367.83	Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)
75966	761.81	70.89	690.92	Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation
75968	387.19	19.36	367.83	Transluminal balloon angioplasty, each additional visceral artery, radiological

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
				supervision and interpretation (List separately in addition to code for primary procedure)
75970	551.57	45.02	506.55	Transcatheter biopsy, radiological supervision and interpretation
75978	719.47	28.55	690.92	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation
75980	314.22	76.21	238.01	Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation
75982	343.67	75.79	267.88	Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation
75984	124.39	38.47	85.92	Change of percutaneous tube or drainage catheter with contrast monitoring (eg, gastrointestinal system, genitourinary system, abscess), radiological supervision and interpretation
75989	201.41	62.69	138.72	Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation
75992	719.89	28.97	690.92	Transluminal atherectomy, peripheral artery, radiological supervision and interpretation
75993	387.61	19.78	367.83	Transluminal atherectomy, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)
75994	761.81	70.89	690.92	Transluminal atherectomy, renal, radiological supervision and interpretation
75995	762.23	71.31	690.92	Transluminal atherectomy, visceral, radiological supervision and interpretation
75996	386.76	18.93	367.83	Transluminal atherectomy, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)
75998	79.53	21.31	58.22	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)
76000	66.14	8.82	57.32	Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)
76001	150.38	35.74	114.64	Fluoroscopy, physician time more than one hour, assisting a non-radiologic physician (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)
76003	86.05	28.73	57.32	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)
76005	87.89	30.57	57.32	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction
76006	I.C.			Manual application of stress performed by physician for joint radiography, including contralateral joint if indicated
76010	32.14	9.62	22.52	Radiologic examination from nose to rectum for foreign body, single view, child
76012	77.19	77.19		Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under fluoroscopic guidance
76013	89.24	89.24		Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under CT guidance
76020	32.51	9.99	22.52	Bone age studies
76040	49.98	15.18	34.80	Bone length studies (orthoroentgenogram, scanogram)
76061	67.84	23.89	43.95	Radiologic examination, osseous survey; limited (eg, for metastases)

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
76062	91.65	28.55	63.10	Radiologic examination, osseous survey; complete (axial and appendicular skeleton)
76065	69.50	36.81	32.69	Radiologic examination, osseous survey, infant
76066	65.94	16.93	49.01	Joint survey, single view, two or more joints (specify)
76070	142.67	13.10	129.57	Computed tomography, bone mineral density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)
76071	137.82	11.55	126.27	Computed tomography, bone mineral density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)
76075	152.03	15.83	136.20	Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)
76076	45.51	11.97	33.54	Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)
76078	44.33	10.79	33.54	Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), one or more sites
76080	75.03	28.55	46.48	Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation
76082	20.99	3.41	17.58	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)
76083	20.99	3.41	17.58	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)
76086	133.87	19.23	114.64	Mammary ductogram or galactogram, single duct, radiological supervision and interpretation
76088	184.71	23.89	160.82	Mammary ductogram or galactogram, multiple ducts, radiological supervision and interpretation
76090	83.77	37.29	46.48	Mammography; unilateral
76091	103.55	46.23	57.32	Mammography; bilateral
76092	91.24	37.29	53.95	Screening mammography, bilateral (two view film study of each breast)
76093	859.07	86.21	772.86	Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral
76094	1,134.66	86.21	1,048.45	Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral
76095	399.36	85.18	314.18	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
76096	87.65	30.33	57.32	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
76098	26.32	8.44	17.88	Radiological examination, surgical specimen
76100	85.87	31.08	54.79	Radiologic examination, single plane body section (eg, tomography), other than with urography
76101	93.76	31.08	62.68	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral
76102	108.15	31.50	76.65	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral
76120	66.89	20.41	46.48	Cineradiography/videoradiography, except where specifically included
76125	49.08	14.28	34.80	Cineradiography/videoradiography to complement routine examination (List separately in addition to code for primary procedure)
76140	I.C.			Consultation on x-ray examination made elsewhere, written report

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
76150	I.C.			Xeroradiography
76350	I.C.			Subtraction in conjunction with contrast studies
76355	426.64	64.59	362.05	Computed tomography guidance for stereotactic localization
76360	423.19	61.14	362.05	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation
76362	605.09	211.86	393.23	Computed tomography guidance for, and monitoring of, visceral tissue ablation
76370	174.93	45.36	129.57	Computed tomography guidance for placement of radiation therapy fields
76375	163.48	8.44	155.04	Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality
76380	205.73	52.37	153.36	Computed tomography, limited or localized follow-up study
76390	556.51	74.71	481.80	Magnetic resonance spectroscopy
76393	570.34	80.04	490.30	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation
76394	745.96	225.38	520.58	Magnetic resonance guidance for, and monitoring of, visceral tissue ablation
76400	576.16	84.66	491.50	Magnetic resonance (eg, proton) imaging, bone marrow blood supply
76496	I.C.	I.C.	I.C.	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)
76497	I.C.	I.C.	I.C.	Unlisted computed tomography procedure (eg, diagnostic, interventional)
76498	I.C.	I.C.	I.C.	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)
76499	I.C.	I.C.	I.C.	Unlisted diagnostic radiographic procedure
76506	98.18	35.50	62.68	Echoencephalography, B-scan and/or real time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated
76511	115.29	52.91	62.38	Ophthalmic ultrasound, echography, diagnostic; A-scan only, with amplitude quantification
76512	101.96	37.84	64.12	Ophthalmic ultrasound, echography, diagnostic; contact B-scan (with or without simultaneous A-scan)
76513	105.76	37.84	67.92	Ophthalmic ultrasound, echography, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy
76514	12.91	10.08	2.83	Ophthalmic ultrasound, echography, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
76516	83.88	31.20	52.68	Ophthalmic biometry by ultrasound echography, A-scan;
76519	87.68	31.20	56.48	Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation
76529	83.21	32.33	50.88	Ophthalmic ultrasonic foreign body localization
76536	92.41	29.73	62.68	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), B-scan and/or real time with image documentation
76604	86.25	28.93	57.32	Ultrasound, chest, B-scan (includes mediastinum) and/or real time with image documentation
76645	75.63	29.15	46.48	Ultrasound, breast(s) (unilateral or bilateral), B-scan and/or real time with image documentation
76700	130.19	43.43	86.76	Ultrasound, abdominal, B-scan and/or real time with image documentation; complete
76705	94.56	31.88	62.68	Ultrasound, abdominal, B-scan and/or real time with image documentation; limited (eg, single organ, quadrant, follow-up)
76770	126.40	39.64	86.76	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
76775	93.76	31.08	62.68	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; limited
76778	126.40	39.64	86.76	Ultrasound, transplanted kidney, B-scan and/or real time with image documentation, with or without duplex Doppler study
76800	121.55	58.87	62.68	Ultrasound, spinal canal and contents
76801	145.71	53.59	92.12	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (
76802	93.30	45.02	48.28	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (
76805	145.71	53.59	92.12	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation
76810	105.39	54.11	51.28	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)
76811	266.99	104.87	162.12	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	154.86	97.88	56.98	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)
76815	97.49	34.81	62.68	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses
76816	95.15	46.14	49.01	Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus
76817	106.56	40.69	65.87	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76818	128.40	57.11	71.29	Fetal biophysical profile; with non-stress testing
76819	112.73	41.44	71.29	Fetal biophysical profile; without non-stress testing
76825	177.13	90.37	86.76	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
76826	76.15	44.72	31.43	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study
76827	108.27	31.75	76.52	Doppler echocardiography, fetal, cardiovascular system, pulsed wave and/or continuous wave with spectral display; complete
76828	80.60	30.99	49.61	Doppler echocardiography, fetal, cardiovascular system, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study
76830	103.99	36.92	67.07	Ultrasound, transvaginal
76831	105.78	38.71	67.07	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed
76856	103.99	36.92	67.07	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete
76857	88.39	20.41	67.98	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; limited or follow-up (eg, for follicles)
76870	101.26	34.19	67.07	Ultrasound, scrotum and contents
76872	118.61	37.21	81.40	Ultrasound, transrectal;
76873	175.43	82.11	93.32	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
				(separate procedure)
76880	94.56	31.88	62.68	Ultrasound, extremity, non-vascular, B-scan and/or real time with image documentation
76885	106.71	39.64	67.07	Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)
76886	96.11	33.43	62.68	Ultrasound, infant hips, real time with imaging documentation; limited, static (not requiring physician manipulation)
76930	103.90	36.83	67.07	Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation
76932	103.90	36.83	67.07	Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation
76936	383.37	106.76	276.61	Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging)
76937	35.63	17.03	18.60	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)
76940	179.49	106.72	72.77	Ultrasound guidance for, and monitoring of, visceral tissue ablation
76941	139.33	72.44	66.89	Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation
76942	146.11	36.04	110.07	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation
76945	103.05	36.16	66.89	Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation
76946	87.60	20.53	67.07	Ultrasonic guidance for amniocentesis, imaging supervision and interpretation
76948	87.48	20.41	67.07	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation
76950	88.40	31.08	57.32	Ultrasonic guidance for placement of radiation therapy fields
76965	314.98	70.64	244.34	Ultrasonic guidance for interstitial radioelement application
76970	67.64	21.16	46.48	Ultrasound study follow-up (specify)
76975	110.62	43.55	67.07	Gastrointestinal endoscopic ultrasound, supervision and interpretation
76977	39.52	3.03	36.49	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
76986	179.15	64.51	114.64	Ultrasonic guidance, intraoperative
76999	I.C.	I.C.	I.C.	Unlisted ultrasound procedure (eg, diagnostic, interventional)
77261	I.C.			Therapeutic radiology treatment planning; simple
77262	I.C.			Therapeutic radiology treatment planning; intermediate
77263	I.C.			Therapeutic radiology treatment planning; complex
77280	188.96	36.87	152.09	Therapeutic radiology simulation-aided field setting; simple
77285	300.07	55.43	244.64	Therapeutic radiology simulation-aided field setting; intermediate
77290	367.34	81.58	285.76	Therapeutic radiology simulation-aided field setting; complex
77295	1,465.63	239.68	1,225.95	Therapeutic radiology simulation-aided field setting; three-dimensional
77299	I.C.	I.C.	I.C.	Unlisted procedure, therapeutic radiology clinical treatment planning
77300	92.02	33.01	59.01	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician
77301	1,640.93	414.98	1,225.95	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
77305	119.42	37.29	82.13	Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two

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				parallel opposed unmodified ports directed to a single area of interest)
77310	157.97	55.43	102.54	Teletherapy, isodose plan (whether hand or computer calculated); intermediate (three or more treatment ports directed to a single area of interest)
77315	197.91	81.58	116.33	Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)
77321	227.83	50.39	177.44	Special teletherapy port plan, particles, hemibody, total body
77326	153.02	49.22	103.80	Brachytherapy isodose plan; simple (calculation made from single plane, one to four sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)
77327	225.15	73.06	152.09	Brachytherapy isodose plan; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)
77328	326.94	109.94	217.00	Brachytherapy isodose plan; complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)
77331	67.79	46.11	21.68	Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician
77332	87.14	28.13	59.01	Treatment devices, design and construction; simple (simple block, simple bolus)
77333	127.95	44.56	83.39	Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)
77334	207.52	65.00	142.52	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
77336	I.C.			Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy
77370	I.C.			Special medical radiation physics consultation
77399	I.C.	I.C.	I.C.	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services
77401	I.C.			Radiation treatment delivery, superficial and/or ortho voltage
77402	I.C.			Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV
77403	I.C.			Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV
77404	I.C.			Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV
77406	I.C.			Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater
77407	I.C.			Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; up to 5 MeV
77408	I.C.			Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 6-10 MeV
77409	I.C.			Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 11-19 MeV
77411	I.C.			Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater
77412	I.C.			Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (eg, electron or neutrons); up to 5 MeV

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
77413	I.C.			Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (eg, electron or neutrons); 6-10 MeV
77414	I.C.			Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (eg, electron or neutrons); 11-19 MeV
77416	I.C.			Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (eg, electron or neutrons); 20 MeV or greater
77417	I.C.			Therapeutic radiology port film(s)
77418	I.C.			Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams (eg, binary, dynamic MLC), per treatment session
77427	I.C.			Radiation treatment management, five treatments
77431	I.C.			Radiation therapy management with complete course of therapy consisting of one or two fractions only
77432	I.C.			Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session)
77470	599.33	109.94	489.39	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)
77499	I.C.	I.C.	I.C.	Unlisted procedure, therapeutic radiology treatment management
77520	I.C.			Proton treatment delivery; simple, without compensation
77522	I.C.			Proton treatment delivery; simple, with compensation
77523	I.C.			Proton treatment delivery; intermediate
77525	I.C.			Proton treatment delivery; complex
77600	216.27	82.48	133.79	Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)
77605	290.01	111.43	178.58	Hyperthermia, externally generated; deep (ie, heating to depths greater than 4 cm)
77610	216.09	82.30	133.79	Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators
77615	288.52	109.94	178.58	Hyperthermia generated by interstitial probe(s); more than 5 interstitial applicators
77620	216.22	82.43	133.79	Hyperthermia generated by intracavitary probe(s)
77750	315.84	257.26	58.58	Infusion or instillation of radioelement solution
77761	305.80	195.37	110.43	Intracavitary radiation source application; simple
77762	458.86	300.57	158.29	Intracavitary radiation source application; intermediate
77763	646.35	449.76	196.59	Intracavitary radiation source application; complex
77776	320.31	224.52	95.79	Interstitial radiation source application; simple
77777	578.63	392.88	185.75	Interstitial radiation source application; intermediate
77778	812.73	587.54	225.19	Interstitial radiation source application; complex
77781	978.22	87.34	890.88	Remote afterloading high intensity brachytherapy; 1-4 source positions or catheters
77782	1,022.10	131.22	890.88	Remote afterloading high intensity brachytherapy; 5-8 source positions or catheters
77783	1,086.30	195.42	890.88	Remote afterloading high intensity brachytherapy; 9-12 source positions or catheters
77784	1,185.19	294.31	890.88	Remote afterloading high intensity brachytherapy; over 12 source positions or catheters
77789	78.60	59.03	19.57	Surface application of radiation source
77790	77.11	55.43	21.68	Supervision, handling, loading of radiation source
77799	I.C.	I.C.	I.C.	Unlisted procedure, clinical brachytherapy

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
78000	53.11	10.42	42.69	Thyroid uptake; single determination
78001	71.22	13.90	57.32	Thyroid uptake; multiple determinations
78003	60.07	17.38	42.69	Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies)
78006	130.89	26.24	104.65	Thyroid imaging, with uptake; single determination
78007	140.00	26.62	113.38	Thyroid imaging, with uptake; multiple determinations
78010	101.23	20.79	80.44	Thyroid imaging; only
78011	129.80	23.89	105.91	Thyroid imaging; with vascular flow
78015	149.54	36.16	113.38	Thyroid carcinoma metastases imaging; limited area (eg, neck and chest only)
78016	196.86	44.35	152.51	Thyroid carcinoma metastases imaging; with additional studies (eg, urinary recovery)
78018	284.71	46.28	238.43	Thyroid carcinoma metastases imaging; whole body
78020	91.50	32.08	59.42	Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)
78070	124.37	43.93	80.44	Parathyroid imaging
78075	278.92	40.49	238.43	Adrenal imaging, cortex and/or medulla
78099	I.C.	I.C.	I.C.	Unlisted endocrine procedure, diagnostic nuclear medicine
78102	119.36	29.77	89.59	Bone marrow imaging; limited area
78103	179.59	40.44	139.15	Bone marrow imaging; multiple areas
78104	221.76	42.75	179.01	Bone marrow imaging; whole body
78110	52.27	10.42	41.85	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling
78111	125.35	11.97	113.38	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple samplings
78120	89.00	12.35	76.65	Red cell volume determination (separate procedure); single sampling
78121	144.29	17.00	127.29	Red cell volume determination (separate procedure); multiple samplings
78122	226.26	24.31	201.95	Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)
78130	157.82	33.06	124.76	Red cell survival study;
78135	248.24	34.61	213.63	Red cell survival study; differential organ/tissue kinetics, (eg, splenic and/or hepatic sequestration)
78140	205.43	32.63	172.80	Labeled red cell sequestration, differential organ/tissue, (eg, splenic and/or hepatic)
78160	179.52	18.70	160.82	Plasma radioiron disappearance (turnover) rate
78162	165.69	25.28	140.41	Radioiron oral absorption
78170	255.94	22.86	233.08	Radioiron red cell utilization
78172	28.17	28.17		Chelatable iron for estimation of total body iron
78185	125.39	21.59	103.80	Spleen imaging only, with or without vascular flow
78190	310.18	59.64	250.54	Kinetics, study of platelet survival, with or without differential organ/tissue localization
78191	353.98	32.63	321.35	Platelet survival study
78195	243.34	64.33	179.01	Lymphatics and lymph nodes imaging
78199	I.C.	I.C.	I.C.	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine
78201	127.32	23.52	103.80	Liver imaging; static only
78202	153.44	27.42	126.02	Liver imaging; with vascular flow
78205	297.78	38.51	259.27	Liver imaging (SPECT);

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
78206	305.30	52.03	253.27	Liver imaging (SPECT); with vascular flow
78215	154.79	26.24	128.55	Liver and spleen imaging; static only
78216	183.04	30.53	152.51	Liver and spleen imaging; with vascular flow
78220	189.59	26.24	163.35	Liver function study with hepatobiliary agents, with serial images
78223	205.80	44.98	160.82	Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function
78230	119.68	23.89	95.79	Salivary gland imaging;
78231	167.37	28.22	139.15	Salivary gland imaging; with serial images
78232	180.23	25.19	155.04	Salivary gland function study
78258	165.66	39.64	126.02	Esophageal motility
78261	217.61	37.76	179.85	Gastric mucosa imaging
78262	223.55	36.96	186.59	Gastroesophageal reflux study
78264	223.11	42.00	181.11	Gastric emptying study
78267	I.C.			Urea breath test, C-14; acquisition for analysis
78268	I.C.			Urea breath test, C-14; analysis
78270	79.13	10.79	68.34	Vitamin B-12 absorption study (eg, Schilling test); without intrinsic factor
78271	83.34	10.79	72.55	Vitamin B-12 absorption study (eg, Schilling test); with intrinsic factor
78272	116.82	14.70	102.12	Vitamin B-12 absorption studies combined, with and without intrinsic factor
78278	266.80	53.17	213.63	Acute gastrointestinal blood loss imaging
78282	20.41	20.41		Gastrointestinal protein loss
78290	170.33	36.54	133.79	Intestine imaging (eg, ectopic gastric mucosa, Meckel's localization, volvulus)
78291	181.96	47.33	134.63	Peritoneal-venous shunt patency test (eg, for LeVeen, Denver shunt)
78299	I.C.	I.C.	I.C.	Unlisted gastrointestinal procedure, diagnostic nuclear medicine
78300	143.01	33.43	109.58	Bone and/or joint imaging; limited area
78305	205.12	44.30	160.82	Bone and/or joint imaging; multiple areas
78306	233.60	46.16	187.44	Bone and/or joint imaging; whole body
78315	264.55	54.72	209.83	Bone and/or joint imaging; three phase study
78320	315.59	56.32	259.27	Bone and/or joint imaging; tomographic (SPECT)
78350	45.09	11.55	33.54	Bone density (bone mineral content) study, one or more sites; single photon absorptiometry
78351	I.C.			Bone density (bone mineral content) study, one or more sites; dual photon absorptiometry, one or more sites
78399	I.C.	I.C.	I.C.	Unlisted musculoskeletal procedure, diagnostic nuclear medicine
78414	24.31	24.31		Determination of central c-v hemodynamics (non-imaging) (eg, ejection fraction with probe technique) with or without pharmacologic intervention or exercise, single or multiple determinations
78428	142.43	43.26	99.17	Cardiac shunt detection
78445	108.37	26.24	82.13	Non-cardiac vascular flow imaging (ie, angiography, venography)
78455	214.18	39.27	174.91	Venous thrombosis study (eg, radioactive fibrinogen)
78456	231.27	53.96	177.31	Acute venous thrombosis imaging, peptide
78457	157.53	41.20	116.33	Venous thrombosis imaging, venogram; unilateral
78458	225.65	49.05	176.60	Venous thrombosis imaging, venogram; bilateral

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
78459	82.09	82.09		Myocardial imaging, positron emission tomography (PET), metabolic evaluation
78460	150.08	46.28	103.80	Myocardial perfusion imaging; (planar) single study, at rest or stress (exercise and/or pharmacologic), with or without quantification
78461	273.62	66.31	207.31	Myocardial perfusion imaging; multiple studies, (planar) at rest and/or stress (exercise and/or pharmacologic), and redistribution and/or rest injection, with or without quantification
78464	369.01	58.62	310.39	Myocardial perfusion imaging; tomographic (SPECT), single study at rest or stress (exercise and/or pharmacologic), with or without quantification
78465	596.05	78.78	517.27	Myocardial perfusion imaging; tomographic (SPECT), multiple studies, at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification
78466	152.40	37.76	114.64	Myocardial imaging, infarct avid, planar; qualitative or quantitative
78468	203.99	43.17	160.82	Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique
78469	278.66	49.38	229.28	Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification
78472	295.32	53.21	242.11	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing
78473	440.78	78.73	362.05	Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification
78478	102.44	33.68	68.76	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)
78480	102.44	33.68	68.76	Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)
78481	283.03	53.75	229.28	Cardiac blood pool imaging, (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification
78483	424.89	80.00	344.89	Cardiac blood pool imaging, (planar), first pass technique; multiple studies, at rest and with stress (exercise and/ or pharmacologic), wall motion study plus ejection fraction, with or without quantification
78491	83.24	83.24		Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress
78492	103.81	103.81		Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress
78494	371.95	63.66	308.29	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing
78496	335.33	27.04	308.29	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure)
78499	I.C.	I.C.	I.C.	Unlisted cardiovascular procedure, diagnostic nuclear medicine
78580	190.05	39.64	150.41	Pulmonary perfusion imaging, particulate
78584	193.15	52.74	140.41	Pulmonary perfusion imaging, particulate, with ventilation; single breath
78585	305.66	58.50	247.16	Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath
78586	134.96	21.16	113.80	Pulmonary ventilation imaging, aerosol; single projection
78587	148.89	26.24	122.65	Pulmonary ventilation imaging, aerosol; multiple projections (eg, anterior, posterior, lateral views)

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
78588	199.21	58.50	140.71	Pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, one or multiple projections
78591	146.35	21.59	124.76	Pulmonary ventilation imaging, gaseous, single breath, single projection
78593	177.49	26.24	151.25	Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; single projection
78594	246.01	28.17	217.84	Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; multiple projections (eg, anterior, posterior, lateral views)
78596	377.79	67.40	310.39	Pulmonary quantitative differential function (ventilation/perfusion) study
78599	I.C.	I.C.	I.C.	Unlisted respiratory procedure, diagnostic nuclear medicine
78600	149.54	23.52	126.02	Brain imaging, limited procedure; static
78601	176.14	27.00	149.14	Brain imaging, limited procedure; with vascular flow
78605	177.74	28.60	149.14	Brain imaging, complete study; static
78606	204.46	34.61	169.85	Brain imaging, complete study; with vascular flow
78607	354.18	66.31	287.87	Brain imaging, complete study; tomographic (SPECT)
78608	I.C.			Brain imaging, positron emission tomography (PET); metabolic evaluation
78609	I.C.			Brain imaging, positron emission tomography (PET); perfusion evaluation
78610	85.85	16.25	69.60	Brain imaging, vascular flow only
78615	192.19	23.18	169.01	Cerebral vascular flow
78630	257.51	36.54	220.97	Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography
78635	145.83	33.72	112.11	Cerebrospinal fluid flow, imaging (not including introduction of material); ventriculography
78645	180.94	30.53	150.41	Cerebrospinal fluid flow, imaging (not including introduction of material); shunt evaluation
78647	307.90	48.63	259.27	Cerebrospinal fluid flow, imaging (not including introduction of material); tomographic (SPECT)
78650	236.09	32.46	203.63	Cerebrospinal fluid leakage detection and localization
78660	121.13	28.17	92.96	Radiopharmaceutical dacryocystography
78699	I.C.	I.C.	I.C.	Unlisted nervous system procedure, diagnostic nuclear medicine
78700	157.68	23.89	133.79	Kidney imaging; static only
78701	182.13	26.24	155.89	Kidney imaging; with vascular flow
78704	213.29	39.64	173.65	Kidney imaging; with function study (ie, imaging renogram)
78707	247.36	51.61	195.75	Kidney imaging with vascular flow and function; single study without pharmacological intervention
78708	260.46	64.71	195.75	Kidney imaging with vascular flow and function; single study, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)
78709	270.83	75.08	195.75	Kidney imaging with vascular flow and function; multiple studies, with and without pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)
78710	294.63	35.36	259.27	Kidney imaging, tomographic (SPECT)
78715	85.85	16.25	69.60	Kidney vascular flow only
78725	98.86	20.11	78.75	Kidney function study, non-imaging radioisotopic study
78730	83.60	19.66	63.94	Urinary bladder residual study
78740	123.06	30.10	92.96	Ureteral reflux study (radiopharmaceutical voiding cystogram)
78760	152.53	35.36	117.17	Testicular imaging;

Code	Fee Global	Fee PC	Fee TC	40.06(7) – Radiologic Service Description
78761	178.50	38.09	140.41	Testicular imaging; with vascular flow
78799	I.C.	I.C.	I.C.	Unlisted genitourinary procedure, diagnostic nuclear medicine
78800	184.50	35.36	149.14	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area
78801	227.70	42.37	185.33	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); multiple areas
78802	289.23	46.28	242.95	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging
78803	346.49	58.62	287.87	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT)
78804	246.98	57.15	189.83	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging
78805	188.41	39.27	149.14	Radiopharmaceutical localization of inflammatory process; limited area
78806	328.67	46.28	282.39	Radiopharmaceutical localization of inflammatory process; whole body
78807	346.91	59.04	287.87	Radiopharmaceutical localization of inflammatory process; tomographic (SPECT)
78810	107.27	107.27		Tumor imaging, positron emission tomography (PET), metabolic evaluation
78890	60.05	3.03	57.02	Generation of automated data: interactive process involving nuclear physician and/or allied health professional personnel; simple manipulations and interpretation, not to exceed 30 minutes
78891	120.10	5.76	114.34	Generation of automated data: interactive process involving nuclear physician and/or allied health professional personnel; complex manipulations and interpretation, exceeding 30 minutes
78990	I.C.			Provision of diagnostic radiopharmaceutical(s)
78999	I.C.	I.C.	I.C.	Unlisted miscellaneous procedure, diagnostic nuclear medicine
79000	210.21	95.57	114.64	Radiopharmaceutical therapy, hyper-thyroidism; initial, including evaluation of patient
79001	113.59	56.27	57.32	Radiopharmaceutical therapy, hyper-thyroidism; subsequent, each therapy
79020	210.59	95.95	114.64	Radiopharmaceutical therapy, thyroid suppression (euthyroid cardiac disease), including evaluation of patient
79030	226.76	112.12	114.64	Radiopharmaceutical ablation of gland for thyroid carcinoma
79035	250.06	135.42	114.64	Radiopharmaceutical therapy for metastases of thyroid carcinoma
79100	185.61	70.97	114.64	Radiopharmaceutical therapy, polycythemia vera, chronic leukemia, each treatment by intravenous injection
79200	221.17	106.53	114.64	Intracavitary radioactive colloid therapy
79300	86.34	86.34		Interstitial radioactive colloid therapy
79400	219.79	105.15	114.64	Radiopharmaceutical therapy, nonthyroid, nonhematologic by intravenous injection
79403	310.83	125.79	185.04	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion
79420	79.70	79.70		Intravascular radiopharmaceutical therapy, particulate
79440	223.03	108.39	114.64	Intra-articular radiopharmaceutical therapy
79900	I.C.			Provision of therapeutic radiopharmaceutical(s)
79999	I.C.	I.C.	I.C.	Unlisted radiopharmaceutical therapeutic procedure

40.06(10) Freestanding Surgical Services / Surgery
(a) Ambulatory Surgery Global Facility Fees

Group	Boston / New Bedford / Worcester	Pittsfield / Rural	Springfield	Barnstable	National (Out of State)
1	$347.14	$337.96	$339.23	$366.91	$333
2	$464.94	$452.64	$454.34	$491.42	$446
3	$531.66	$517.59	$519.54	$561.94	$510
4	$656.76	$639.38	$641.79	$694.16	$630
5	$747.46	$727.67	$730.41	$790.02	$717
6	$854.71	$836.06	$838.65	$894.84	$826
7	$1037.26	$1009.81	$1013.61	$1096.33	$995
8	$1007.96	$985.25	$988.40	$1056.81	$973
9	$1395.88	$1358.93	$1364.05	$1475.35	$1339

Groups 6 and 8 amount contains $150.00 for intraocular lenses (IOLs)

40.06(8) Freestanding Surgical Services / Surgery

Code	Group	Fee	40.06(8) – Surgical Services Description
10021		143.03	Fine needle aspiration; without imaging guidance
10022		159.71	Fine needle aspiration; with imaging guidance
10040		89.29	Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)
10060		97.70	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
10061		173.10	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple
10080		179.36	Incision and drainage of pilonidal cyst; simple
10081		272.54	Incision and drainage of pilonidal cyst; complicated
10120		111.15	Incision and removal of foreign body, subcutaneous tissues; simple
10121	02	250.81	Incision and removal of foreign body, subcutaneous tissues; complicated
10140		126.75	Incision and drainage of hematoma, seroma or fluid collection
10160		79.92	Puncture aspiration of abscess, hematoma, bulla, or cyst
10180	02	230.84	Incision and drainage, complex, postoperative wound infection
11000		48.45	Debridement of extensive eczematous or infected skin; up to 10% of body surface
11001		21.61	Debridement of extensive eczematous or infected skin; each additional 10% of the body surface (List separately in addition to code for primary procedure)
11010	02	458.32	Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutaneous tissues
11011	02	543.98	Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, and muscle
11012	02	797.42	Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone

Code	Group	Fee	40.06(8) – Surgical Services Description
11040		42.15	Debridement; skin, partial thickness
11041		60.42	Debridement; skin, full thickness
11042	02	86.42	Debridement; skin, and subcutaneous tissue
11043	02	242.19	Debridement; skin, subcutaneous tissue, and muscle
11044	02	317.38	Debridement; skin, subcutaneous tissue, muscle, and bone
11055		40.00	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
11056		50.76	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); two to four lesions
11057		62.06	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than four lesions
11100		85.16	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion
11101		30.39	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)
11200		75.22	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201		18.28	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional ten lesions (List separately in addition to code for primary procedure)
11300		62.59	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less
11301		80.77	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm
11302		96.62	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm
11303		115.88	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm
11305		62.17	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
11306		85.92	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
11307		99.17	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
11308		116.69	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm
11310		76.24	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
11311		93.67	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm
11312		108.05	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm
11313		141.11	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm
11400		118.46	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
11401		136.94	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm
11402		155.99	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm
11403		175.21	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or

Code	Group	Fee	40.06(8) – Surgical Services Description
			legs; excised diameter 2.1 to 3.0 cm
11404	01	199.36	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm
11406	02	243.75	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
11420		114.57	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421		145.13	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm
11422		162.25	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11423		192.12	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11424	02	218.01	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm
11426	02	302.84	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
11440		139.08	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441		160.88	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm
11442		179.14	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm
11443		218.15	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm
11444	01	276.63	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm
11446	02	352.99	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm
11450	02	327.65	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair
11451	02	446.79	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair
11462	02	322.25	Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair
11463	02	456.36	Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with complex repair
11470	02	350.02	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with simple or intermediate repair
11471	02	469.07	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with complex repair
11600		164.41	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.5 cm or less
11601		186.74	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm
11602		198.89	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm
11603		219.38	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm
11604	02	240.85	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm
11606	02	312.42	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm
11620		158.62	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11621		185.65	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm

Code	Group	Fee	40.06(8) – Surgical Services Description
11622		210.67	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11623		247.26	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11624	02	284.15	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm
11626	02	372.50	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
11640		167.90	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less
11641		215.84	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm
11642		249.28	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm
11643		287.89	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm
11644	02	363.40	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm
11646	02	485.41	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm
11719		17.25	Trimming of nondystrophic nails, any number
11720		27.00	Debridement of nail(s) by any method(s); one to five
11721		39.99	Debridement of nail(s) by any method(s); six or more
11730		88.91	Avulsion of nail plate, partial or complete, simple; single
11732		41.42	Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)
11740		50.98	Evacuation of subungual hematoma
11750		165.63	Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;
11752		237.03	Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal; with amputation of tuft of distal phalanx
11755		97.87	Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)
11760		143.44	Repair of nail bed
11762		216.37	Reconstruction of nail bed with graft
11765		75.87	Wedge excision of skin of nail fold (eg, for ingrown toenail)
11770	03	255.50	Excision of pilonidal cyst or sinus; simple
11771	03	476.75	Excision of pilonidal cyst or sinus; extensive
11772	03	589.67	Excision of pilonidal cyst or sinus; complicated
11900		47.61	Injection, intralesional; up to and including seven lesions
11901		59.19	Injection, intralesional; more than seven lesions
11920		150.90	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921		179.76	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm

Code	Group	Fee	40.06(8) – Surgical Services Description
11922		35.87	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm (List separately in addition to code for primary procedure)
11950		82.25	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951		111.70	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952		148.86	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954		179.52	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
11960	02	817.28	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	03	550.88	Replacement of tissue expander with permanent prosthesis
11971	01	387.11	Removal of tissue expander(s) without insertion of prosthesis
11975		120.77	Insertion, implantable contraceptive capsules
11976		145.08	Removal, implantable contraceptive capsules
11977		231.23	Removal with reinsertion, implantable contraceptive capsules
11980		105.78	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
11981		134.26	Insertion, non-biodegradable drug delivery implant
11982		156.46	Removal, non-biodegradable drug delivery implant
11983		233.34	Removal with reinsertion, non-biodegradable drug delivery implant
12001		153.21	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
12002		162.38	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm
12004		190.25	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm
12005	02	236.39	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm
12006	02	293.70	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm
12007	02	331.20	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm
12011		162.52	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12013		178.12	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm
12014		209.39	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm
12015		263.46	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm
12016	02	311.27	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm
12017	02	271.85	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12018	02	320.34	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm
12020	01	219.20	Treatment of superficial wound dehiscence; simple closure

Code	Group	Fee	40.06(8) – Surgical Services Description
12021	01	149.63	Treatment of superficial wound dehiscence; with packing
12031		183.85	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less
12032		262.10	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm
12034	02	251.24	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm
12035	02	361.49	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm
12036	02	392.99	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm
12037	02	463.63	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm
12041		199.79	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less
12042		244.94	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm
12044	02	262.00	Layer closure of wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm
12045	02	303.89	Layer closure of wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm
12046	02	451.24	Layer closure of wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm
12047	02	460.30	Layer closure of wounds of neck, hands, feet and/or external genitalia; over 30.0 cm
12051		235.00	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12052		244.38	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm
12053		260.59	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm
12054	02	288.32	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm
12055	02	370.65	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm
12056	02	497.78	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12057	02	499.51	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm
13100	02	273.11	Repair, complex, trunk; 1.1 cm to 2.5 cm
13101	03	313.62	Repair, complex, trunk; 2.6 cm to 7.5 cm
13102		81.55	Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)
13120	02	285.02	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
13121	03	339.26	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm
13122		95.17	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)
13131	02	315.10	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13132	03	432.98	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
13133		139.05	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)
13150	03	385.64	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less
13151	03	405.26	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm

Code	Group	Fee	40.06(8) – Surgical Services Description
13152	03	508.42	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm
13153		152.83	Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)
13160	02	738.61	Secondary closure of surgical wound or dehiscence, extensive or complicated
14000	02	597.38	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	03	761.43	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14020	03	652.68	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	03	844.01	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
14040	02	663.96	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	03	906.84	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
14060	03	724.21	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061	03	981.21	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm
14300	04	946.21	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area
14350	03	701.44	Filleted finger or toe flap, including preparation of recipient site
15000	02	324.56	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children
15001		98.94	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)
15050	02	429.93	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter
15100	02	907.19	Split graft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)
15101	03	232.91	Split graft, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15120	02	857.42	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)
15121	03	303.65	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15200	03	780.29	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less
15201	02	98.72	Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm (List separately in addition to code for primary procedure)
15220	02	767.40	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less
15221	02	87.43	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm (List separately in addition to code for primary procedure)
15240	03	797.17	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less
15241	03	137.56	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm (List separately in addition to code for primary procedure)
15260	02	817.88	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less
15261	02	205.05	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each

Code	Group	Fee	40.06(8) – Surgical Services Description
			additional 20 sq cm (List separately in addition to code for primary procedure)
15342		118.15	Application of bilaminate skin substitute/neodermis; 25 sq cm
15343		21.41	Application of bilaminate skin substitute/neodermis; each additional 25 sq cm (List separately in addition to code for primary procedure)
15350	02	512.26	Application of allograft, skin; 100 sq cm or less
15351	02	81.23	Application of allograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)
15400	02	341.06	Application of xenograft, skin; 100 sq cm or less
15401	02	93.04	Application of xenograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)
15570	03	768.27	Formation of direct or tubed pedicle, with or without transfer; trunk
15572	03	736.03	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs
15574	03	776.02	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15576	03	749.24	Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral
15600	03	375.69	Delay of flap or sectioning of flap (division and inset); at trunk
15610	03	257.49	Delay of flap or sectioning of flap (division and inset); at scalp, arms, or legs
15620	04	435.53	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet
15630	03	421.84	Delay of flap or sectioning of flap (division and inset); at eyelids, nose, ears, or lips
15650	05	444.66	Transfer, intermediate, of any pedicle flap (eg, abdomen to wrist, Walking tube), any location
15732	03	1,486.77	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)
15734	03	1,490.73	Muscle, myocutaneous, or fasciocutaneous flap; trunk
15736	03	1,442.78	Muscle, myocutaneous, or fasciocutaneous flap; upper extremity
15738	03	1,500.92	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity
15740	02	821.80	Flap; island pedicle
15750	02	852.57	Flap; neurovascular pedicle
15756		2,311.26	Free muscle or myocutaneous flap with microvascular anastomosis
15757		2,364.40	Free skin flap with microvascular anastomosis
15758		2,364.77	Free fascial flap with microvascular anastomosis
15760	02	764.61	Graft; composite (eg, full thickness of external ear or nasal ala), including primary closure, donor area
15770	03	593.40	Graft; derma-fat-fascia
15775	03	281.74	Punch graft for hair transplant; 1 to 15 punch grafts
15776	03	457.34	Punch graft for hair transplant; more than 15 punch grafts
15780		587.25	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781		417.94	Dermabrasion; segmental, face
15782		351.29	Dermabrasion; regional, other than face
15783		378.09	Dermabrasion; superficial, any site, (eg, tattoo removal)
15786		149.16	Abrasion; single lesion (eg, keratosis, scar)
15787		26.53	Abrasion; each additional four lesions or less (List separately in addition to code for primary procedure)
15788		223.51	Chemical peel, facial; epidermal

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15789		464.42	Chemical peel, facial; dermal
15792		206.95	Chemical peel, nonfacial; epidermal
15793		321.47	Chemical peel, nonfacial; dermal
15810		356.80	Salabrasion; 20 sq cm or less
15811		487.76	Salabrasion; over 20 sq cm
15819		684.74	Cervicoplasty
15820	03	493.38	Blepharoplasty, lower eyelid;
15821	03	531.19	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	03	420.02	Blepharoplasty, upper eyelid;
15823	05	605.56	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	03	I.C.	Rhytidectomy; forehead
15825	03	I.C.	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	03	I.C.	Rhytidectomy; glabellar frown lines
15828	03	I.C.	Rhytidectomy; cheek, chin, and neck
15829	05	I.C.	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15831	03	860.44	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty)
15832	03	833.34	Excision, excessive skin and subcutaneous tissue (including lipectomy); thigh
15833	03	790.11	Excision, excessive skin and subcutaneous tissue (including lipectomy); leg
15834	03	775.99	Excision, excessive skin and subcutaneous tissue (including lipectomy); hip
15835	03	960.66	Excision, excessive skin and subcutaneous tissue (including lipectomy); buttock
15836		673.39	Excision, excessive skin and subcutaneous tissue (including lipectomy); arm
15837		678.72	Excision, excessive skin and subcutaneous tissue (including lipectomy); forearm or hand
15838		546.21	Excision, excessive skin and subcutaneous tissue (including lipectomy); submental fat pad
15839		715.62	Excision, excessive skin and subcutaneous tissue (including lipectomy); other area
15840	04	964.61	Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)
15841	04	1,607.64	Graft for facial nerve paralysis; free muscle graft (including obtaining graft)
15842		2,543.41	Graft for facial nerve paralysis; free muscle flap by microsurgical technique
15845	04	896.61	Graft for facial nerve paralysis; regional muscle transfer
15850		97.52	Removal of sutures under anesthesia (other than local), same surgeon
15851		106.73	Removal of sutures under anesthesia (other than local), other surgeon
15852		113.66	Dressing change (for other than burns) under anesthesia (other than local)
15860		132.29	Intravenous injection of agent (eg, fluorescein) to test vascular flow in flap or graft
15876	03	I.C.	Suction assisted lipectomy; head and neck
15877	03	I.C.	Suction assisted lipectomy; trunk
15878	03	I.C.	Suction assisted lipectomy; upper extremity
15879	03	I.C.	Suction assisted lipectomy; lower extremity
15920	03	565.89	Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture
15922	04	719.48	Excision, coccygeal pressure ulcer, with coccygectomy; with flap closure
15931	03	624.93	Excision, sacral pressure ulcer, with primary suture;
15933	03	784.19	Excision, sacral pressure ulcer, with primary suture; with ostectomy
15934	03	870.22	Excision, sacral pressure ulcer, with skin flap closure;

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15935	04	1,043.46	Excision, sacral pressure ulcer, with skin flap closure; with ostectomy
15936	04	866.18	Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;
15937	04	1,009.54	Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure; with ostectomy
15940	03	649.84	Excision, ischial pressure ulcer, with primary suture;
15941	03	878.49	Excision, ischial pressure ulcer, with primary suture; with ostectomy (ischiectomy)
15944	03	841.92	Excision, ischial pressure ulcer, with skin flap closure;
15945	04	938.14	Excision, ischial pressure ulcer, with skin flap closure; with ostectomy
15946	04	1,503.68	Excision, ischial pressure ulcer, with ostectomy, in preparation for muscle or myocutaneous flap or skin graft closure
15950	03	543.33	Excision, trochanteric pressure ulcer, with primary suture;
15951	04	779.70	Excision, trochanteric pressure ulcer, with primary suture; with ostectomy
15952	03	802.01	Excision, trochanteric pressure ulcer, with skin flap closure;
15953	04	907.64	Excision, trochanteric pressure ulcer, with skin flap closure; with ostectomy
15956	03	1,101.25	Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;
15958	04	1,112.15	Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure; with ostectomy
15999		I.C.	Unlisted procedure, excision pressure ulcer
16000		71.91	Initial treatment, first degree burn, when no more than local treatment is required
16010		63.03	Dressings and/or debridement, initial or subsequent; under anesthesia, small
16015	02	145.19	Dressings and/or debridement, initial or subsequent; under anesthesia, medium or large, or with major debridement
16020		87.49	Dressings and/or debridement, initial or subsequent; without anesthesia, office or hospital, small
16025		150.92	Dressings and/or debridement, initial or subsequent; without anesthesia, medium (eg, whole face or whole extremity)
16030		177.77	Dressings and/or debridement, initial or subsequent; without anesthesia, large (eg, more than one extremity)
16035		215.90	Escharotomy; initial incision
16036		85.76	Escharotomy; each additional incision (List separately in addition to code for primary procedure)
17000		65.14	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion
17003		10.59	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; second through 14 lesions, each (List separately in addition to code for first lesion)
17004		207.21	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions
17106		388.20	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm
17107		681.24	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm
17108		937.16	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm
17110		94.72	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of flat warts, molluscum contagiosum, or milia; up to 14 lesions

Code	Group	Fee	40.06(8) – Surgical Services Description
17111		107.01	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of flat warts, molluscum contagiosum, or milia; 15 or more lesions
17250		72.20	Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)
17260		89.77	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less
17261		114.21	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm
17262		141.65	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm
17263		157.76	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 2.1 to 3.0 cm
17264		170.16	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 3.1 to 4.0 cm
17266		198.79	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter over 4.0 cm
17270		123.96	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
17271		133.74	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
17272		153.45	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
17273		173.77	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm
17274		210.33	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm
17276		251.27	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm
17280		114.21	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
17281		147.78	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm
17282		171.70	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm
17283		211.37	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 2.1 to 3.0 cm
17284		250.08	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 3.1 to 4.0 cm
17286		331.54	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 4.0 cm
17304		638.34	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); first stage, fresh tissue technique, up to 5 specimens
17305		272.28	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); second stage, fixed or fresh tissue, up to 5 specimens
17306		273.12	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of

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			specimens by the surgeon, and complete histopathologic preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); third stage, fixed or fresh tissue, up to 5 specimens
17307		271.02	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); additional stage(s), up to 5 specimens, each stage
17310		107.18	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); each additional specimen, after the first 5 specimens, fixed or fresh tissue, any stage (List separately in addition to code for primary procedure)
17340		45.76	Cryotherapy (CO2 slush, liquid N2) for acne
17360		117.57	Chemical exfoliation for acne (eg, acne paste, acid)
17380		I.C.	Electrolysis epilation, each 1/2 hour
17999		I.C.	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19000		119.65	Puncture aspiration of cyst of breast;
19001		50.34	Puncture aspiration of cyst of breast; each additional cyst (List separately in addition to code for primary procedure)
19020	02	399.77	Mastotomy with exploration or drainage of abscess, deep
19030		202.15	Injection procedure only for mammary ductogram or galactogram
19100	01	142.12	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)
19101	02	324.82	Biopsy of breast; open, incisional
19102	02	247.99	Biopsy of breast; percutaneous, needle core, using imaging guidance
19103	02	653.65	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
19110	02	423.01	Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct
19112	03	396.31	Excision of lactiferous duct fistula
19120	03	422.75	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19140), open, male or female, one or more lesions
19125	03	453.94	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion
19126	03	163.86	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker (List separately in addition to code for primary procedure)
19140	04	519.65	Mastectomy for gynecomastia
19160	03	393.13	Mastectomy, partial;
19162	07	828.18	Mastectomy, partial; with axillary lymphadenectomy
19180	04	576.56	Mastectomy, simple, complete
19182	04	522.37	Mastectomy, subcutaneous
19200		976.87	Mastectomy, radical, including pectoral muscles, axillary lymph nodes
19220		998.30	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)
19240		1,010.12	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle
19260		1,117.20	Excision of chest wall tumor including ribs

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19271		1,562.22	Excision of chest wall tumor involving ribs, with plastic reconstruction; without mediastinal lymphadenectomy
19272		1,711.79	Excision of chest wall tumor involving ribs, with plastic reconstruction; with mediastinal lymphadenectomy
19290	01	176.87	Preoperative placement of needle localization wire, breast;
19291	01	98.73	Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure)
19295		117.07	Image guided placement, metallic localization clip, percutaneous, during breast biopsy (List separately in addition to code for primary procedure)
19316	04	764.00	Mastopexy
19318	04	1,121.58	Reduction mammaplasty
19324	04	450.41	Mammaplasty, augmentation; without prosthetic implant
19325	09	628.75	Mammaplasty, augmentation; with prosthetic implant
19328	01	449.73	Removal of intact mammary implant
19330	01	571.10	Removal of mammary implant material
19340	02	394.44	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	03	843.50	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	04	969.07	Nipple/areola reconstruction
19355	04	853.45	Correction of inverted nipples
19357	05	1,338.29	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19361		1,297.01	Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant
19364		2,681.91	Breast reconstruction with free flap
19366	05	1,356.89	Breast reconstruction with other technique
19367		1,767.72	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;
19368		2,201.56	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
19369		2,074.48	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
19370	04	627.35	Open periprosthetic capsulotomy, breast
19371	04	720.55	Periprosthetic capsulectomy, breast
19380	05	706.79	Revision of reconstructed breast
19396		333.88	Preparation of moulage for custom breast implant
19499		I.C.	Unlisted procedure, breast
20000		185.73	Incision of soft tissue abscess (eg, secondary to osteomyelitis); superficial
20005	02	281.68	Incision of soft tissue abscess (eg, secondary to osteomyelitis); deep or complicated
20100		659.12	Exploration of penetrating wound (separate procedure); neck
20101		254.90	Exploration of penetrating wound (separate procedure); chest
20102		308.76	Exploration of penetrating wound (separate procedure); abdomen/flank/back
20103		394.69	Exploration of penetrating wound (separate procedure); extremity
20150		854.22	Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision
20200	02	195.82	Biopsy, muscle; superficial
20205	03	271.53	Biopsy, muscle; deep

Code	Group	Fee	40.06(8) – Surgical Services Description
20206	01	173.06	Biopsy, muscle, percutaneous needle
20220	01	249.38	Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)
20225	02	281.81	Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)
20240	02	243.40	Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur)
20245	03	577.00	Biopsy, bone, open; deep (eg, humerus, ischium, femur)
20250	03	398.68	Biopsy, vertebral body, open; thoracic
20251	03	455.71	Biopsy, vertebral body, open; lumbar or cervical
20500		297.85	Injection of sinus tract; therapeutic (separate procedure)
20501		157.59	Injection of sinus tract; diagnostic (sinogram)
20520		170.91	Removal of foreign body in muscle or tendon sheath; simple
20525	03	290.59	Removal of foreign body in muscle or tendon sheath; deep or complicated
20526		78.44	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel
20550		60.31	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")
20551		59.05	Injection(s); single tendon origin/insertion
20552		57.76	Injection(s); single or multiple trigger point(s), one or two muscle(s)
20553		65.79	Injection(s); single or multiple trigger point(s), three or more muscle(s)
20600		53.97	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)
20605		59.36	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
20610		72.41	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)
20612		58.43	Aspiration and/or injection of ganglion cyst(s) any location
20615		199.95	Aspiration and injection for treatment of bone cyst
20650	03	196.30	Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)
20660		241.46	Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)
20661		425.97	Application of halo, including removal; cranial
20662		486.81	Application of halo, including removal; pelvic
20663		432.93	Application of halo, including removal; femoral
20664		653.88	Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta), requiring general anesthesia
20665		142.11	Removal of tongs or halo applied by another physician
20670	01	356.02	Removal of implant; superficial, (eg, buried wire, pin or rod) (separate procedure)
20680	03	278.18	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)
20690	02	253.57	Application of a uniplane (pins or wires in one plane), unilateral, external fixation system
20692	03	420.17	Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)
20693	03	485.02	Adjustment or revision of external fixation system requiring anesthesia (eg, new pin(s) or wire(s) and/or new ring(s) or bar(s))
20694	01	466.36	Removal, under anesthesia, of external fixation system
20802		2,661.80	Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputation
20805		3,503.53	Replantation, forearm (includes radius and ulna to radial carpal joint), complete amputation
20808		4,386.98	Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation

Code	Group	Fee	40.06(8) – Surgical Services Description
20816		2,924.89	Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation
20822		2,587.77	Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion), complete amputation
20824		2,897.72	Replantation, thumb (includes carpometacarpal joint to MP joint), complete amputation
20827		2,710.20	Replantation, thumb (includes distal tip to MP joint), complete amputation
20838		2,727.91	Replantation, foot, complete amputation
20900	03	546.08	Bone graft, any donor area; minor or small (eg, dowel or button)
20902	04	611.89	Bone graft, any donor area; major or large
20910	03	518.70	Cartilage graft; costochondral
20912	03	515.59	Cartilage graft; nasal septum
20920	04	403.57	Fascia lata graft; by stripper
20922	03	564.37	Fascia lata graft; by incision and area exposure, complex or sheet
20924	04	523.22	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)
20926	04	442.37	Tissue grafts, other (eg, paratenon, fat, dermis)
20930		I.C.	Allograft for spine surgery only; morselized
20931		119.75	Allograft for spine surgery only; structural
20936		I.C.	Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision
20937		182.35	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)
20938		198.54	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision)
20950		110.54	Monitoring of interstitial fluid pressure (includes insertion of device, eg, wick catheter technique, needle manometer technique) in detection of muscle compartment syndrome
20955		2,688.05	Bone graft with microvascular anastomosis; fibula
20956		2,735.26	Bone graft with microvascular anastomosis; iliac crest
20957		2,542.45	Bone graft with microvascular anastomosis; metatarsal
20962		2,779.61	Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsal
20969		2,968.81	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe
20970		2,878.72	Free osteocutaneous flap with microvascular anastomosis; iliac crest
20972		2,756.93	Free osteocutaneous flap with microvascular anastomosis; metatarsal
20973		2,957.28	Free osteocutaneous flap with microvascular anastomosis; great toe with web space
20974		52.81	Electrical stimulation to aid bone healing; noninvasive (nonoperative)
20975	02	186.27	Electrical stimulation to aid bone healing; invasive (operative)
20979		57.34	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)
20982		4,735.76	Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance
20999		I.C.	Unlisted procedure, musculoskeletal system, general
21010	02	706.74	Arthrotomy, temporomandibular joint
21015	03	451.11	Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp
21025	02	837.07	Excision of bone (eg, for osteomyelitis or bone abscess); mandible

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21026	02	489.46	Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s)
21029	02	679.58	Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)
21030	01	479.24	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage
21031	01	325.44	Excision of torus mandibularis
21032	01	327.25	Excision of maxillary torus palatinus
21034	03	1,230.11	Excision of malignant tumor of maxilla or zygoma
21040	02	465.81	Excision of benign tumor or cyst of mandible, by enucleation and/or curettage
21044	02	843.87	Excision of malignant tumor of mandible;
21045		1,134.32	Excision of malignant tumor of mandible; radical resection
21046	02	1,061.00	Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))
21047	02	1,327.96	Excision of benign tumor or cyst of mandible; requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))
21048		1,091.66	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))
21049		1,263.51	Excision of benign tumor or cyst of maxilla; requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s))
21050	03	868.17	Condylectomy, temporomandibular joint (separate procedure)
21060	02	840.11	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)
21070	03	629.48	Coronoidectomy (separate procedure)
21076		1,090.27	Impression and custom preparation; surgical obturator prosthesis
21077		2,752.33	Impression and custom preparation; orbital prosthesis
21079		1,835.13	Impression and custom preparation; interim obturator prosthesis
21080		2,100.50	Impression and custom preparation; definitive obturator prosthesis
21081		1,896.88	Impression and custom preparation; mandibular resection prosthesis
21082		1,676.68	Impression and custom preparation; palatal augmentation prosthesis
21083		1,613.12	Impression and custom preparation; palatal lift prosthesis
21084		1,861.72	Impression and custom preparation; speech aid prosthesis
21085		721.56	Impression and custom preparation; oral surgical splint
21086		2,029.74	Impression and custom preparation; auricular prosthesis
21087		2,025.65	Impression and custom preparation; nasal prosthesis
21088		I.C.	Impression and custom preparation; facial prosthesis
21089		I.C.	Unlisted maxillofacial prosthetic procedure
21100	02	402.26	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)
21110	01	502.21	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
21116		340.91	Injection procedure for temporomandibular joint arthrography
21120		568.25	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	07	747.79	Genioplasty; sliding osteotomy, single piece
21122	07	640.66	Genioplasty; sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	07	810.26	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)

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21125		924.08	Augmentation, mandibular body or angle; prosthetic material
21127	09	1,058.25	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137		702.76	Reduction forehead; contouring only
21138		904.46	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139		999.34	Reduction forehead; contouring and setback of anterior frontal sinus wall
21141		1,325.59	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
21142		1,301.56	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft
21143		1,363.87	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, without bone graft
21145		1,422.85	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21146		1,514.09	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
21147		1,519.23	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
21150		1,584.80	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)
21151		1,892.76	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)
21154		2,175.41	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I
21155		2,435.46	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I
21159		2,871.18	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160		2,936.23	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I
21172		1,708.92	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175		2,207.31	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179		1,553.99	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180		1,703.49	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21181	07	737.26	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial
21182		2,132.22	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm
21183		2,329.63	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm
21184		2,539.38	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and

Code	Group	Fee	40.06(8) – Surgical Services Description
			extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm
21188		1,552.61	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
21193		1,247.81	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194		1,390.10	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)
21195		1,251.44	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196		1,355.54	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21198		1,030.79	Osteotomy, mandible, segmental;
21199		1,035.59	Osteotomy, mandible, segmental; with genioglossus advancement
21206	05	1,023.23	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)
21208	07	1,029.12	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	05	775.84	Osteoplasty, facial bones; reduction
21210	07	993.90	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21215	07	1,011.10	Graft, bone; mandible (includes obtaining graft)
21230	07	801.43	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235	07	751.22	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21240	04	1,106.11	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
21242	05	1,052.97	Arthroplasty, temporomandibular joint, with allograft
21243	05	1,603.03	Arthroplasty, temporomandibular joint, with prosthetic joint replacement
21244	07	905.04	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
21245	07	1,156.95	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246	07	1,126.61	Reconstruction of mandible or maxilla, subperiosteal implant; complete
21247		1,688.14	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
21248	07	1,017.59	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
21249	07	1,408.84	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete
21255		1,208.90	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256		1,160.27	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)
21260		1,045.20	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261		2,074.86	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach
21263		1,690.58	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement
21267	07	1,317.75	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268		1,595.93	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach
21270	05	913.04	Malar augmentation, prosthetic material
21275	07	828.72	Secondary revision of orbitocraniofacial reconstruction
21280	05	492.79	Medial canthopexy (separate procedure)
21282	05	336.01	Lateral canthopexy
21295	01	181.37	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy);

Code	Group	Fee	40.06(8) – Surgical Services Description
			extraoral approach
21296	01	357.43	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach
21299		I.C.	Unlisted craniofacial and maxillofacial procedure
21300	02	130.78	Closed treatment of skull fracture without operation
21310	02	122.31	Closed treatment of nasal bone fracture without manipulation
21315	02	188.87	Closed treatment of nasal bone fracture; without stabilization
21320	02	254.32	Closed treatment of nasal bone fracture; with stabilization
21325	04	310.96	Open treatment of nasal fracture; uncomplicated
21330	05	442.47	Open treatment of nasal fracture; complicated, with internal and/or external skeletal fixation
21335	07	634.47	Open treatment of nasal fracture; with concomitant open treatment of fractured septum
21336	04	487.39	Open treatment of nasal septal fracture, with or without stabilization
21337	02	325.32	Closed treatment of nasal septal fracture, with or without stabilization
21338	04	514.92	Open treatment of nasoethmoid fracture; without external fixation
21339	05	616.83	Open treatment of nasoethmoid fracture; with external fixation
21340	04	803.01	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus
21343		953.42	Open treatment of depressed frontal sinus fracture
21344		1,382.52	Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches
21345	07	815.39	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint
21346		985.83	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation
21347		930.71	Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches
21348		1,159.29	Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft)
21355	03	350.41	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation
21356		660.95	Open treatment of depressed zygomatic arch fracture (eg, Gillies approach)
21360		847.64	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod
21365		1,106.25	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches
21366		1,210.63	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)
21385		666.17	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)
21386		687.95	Open treatment of orbital floor blowout fracture; periorbital approach
21387		711.44	Open treatment of orbital floor blowout fracture; combined approach
21390		744.09	Open treatment of orbital floor blowout fracture; periorbital approach, with alloplastic or other implant
21395		909.57	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)
21400	02	213.81	Closed treatment of fracture of orbit, except blowout; without manipulation
21401	03	348.11	Closed treatment of fracture of orbit, except blowout; with manipulation

Code	Group	Fee	40.06(8) – Surgical Services Description
21406		552.94	Open treatment of fracture of orbit, except blowout; without implant
21407		649.58	Open treatment of fracture of orbit, except blowout; with implant
21408		899.32	Open treatment of fracture of orbit, except blowout; with bone grafting (includes obtaining graft)
21421	04	626.91	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint
21422		813.76	Open treatment of palatal or maxillary fracture (LeFort I type);
21423		783.80	Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches
21431		735.83	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint
21432		605.03	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation
21433		1,752.96	Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches
21435		1,255.66	Open treatment of craniofacial separation (LeFort III type); complicated, utilizing internal and/or external fixation techniques (eg, head cap, halo device, and/or intermaxillary fixation)
21436		1,916.33	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)
21440	03	449.25	Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21445	04	662.80	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21450	03	569.34	Closed treatment of mandibular fracture; without manipulation
21451	04	567.06	Closed treatment of mandibular fracture; with manipulation
21452	02	410.67	Percutaneous treatment of mandibular fracture, with external fixation
21453	03	668.85	Closed treatment of mandibular fracture with interdental fixation
21454	05	538.71	Open treatment of mandibular fracture with external fixation
21461	04	858.85	Open treatment of mandibular fracture; without interdental fixation
21462	05	990.28	Open treatment of mandibular fracture; with interdental fixation
21465	04	902.31	Open treatment of mandibular condylar fracture
21470		1,142.86	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints
21480	01	107.00	Closed treatment of temporomandibular dislocation; initial or subsequent
21485	02	411.58	Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent
21490	03	911.19	Open treatment of temporomandibular dislocation
21493	03	171.21	Closed treatment of hyoid fracture; without manipulation
21494	04	492.61	Closed treatment of hyoid fracture; with manipulation
21495		481.39	Open treatment of hyoid fracture
21497	02	431.97	Interdental wiring, for condition other than fracture
21499		I.C.	Unlisted musculoskeletal procedure, head
21501	02	354.32	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax;
21502	02	536.88	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax; with partial rib ostectomy
21510		481.49	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax
21550		235.92	Biopsy, soft tissue of neck or thorax
21555	02	391.65	Excision tumor, soft tissue of neck or thorax; subcutaneous

Code	Group	Fee	40.06(8) – Surgical Services Description
21556	02	401.51	Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular
21557		594.69	Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or thorax
21600	02	533.33	Excision of rib, partial
21610	02	998.13	Costotransversectomy (separate procedure)
21615		699.00	Excision first and/or cervical rib;
21616		839.99	Excision first and/or cervical rib; with sympathectomy
21620		539.44	Ostectomy of sternum, partial
21627		558.43	Sternal debridement
21630		1,230.17	Radical resection of sternum;
21632		1,232.48	Radical resection of sternum; with mediastinal lymphadenectomy
21685		960.39	Hyoid myotomy and suspension
21700	02	500.44	Division of scalenus anticus; without resection of cervical rib
21705		632.25	Division of scalenus anticus; with resection of cervical rib
21720	03	473.18	Division of sternocleidomastoid for torticollis, open operation; without cast application
21725	03	528.59	Division of sternocleidomastoid for torticollis, open operation; with cast application
21740		1,057.45	Reconstructive repair of pectus excavatum or carinatum; open
21742		I.C.	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
21743		I.C.	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy
21750		713.09	Closure of median sternotomy separation with or without debridement (separate procedure)
21800	01	128.02	Closed treatment of rib fracture, uncomplicated, each
21805	02	255.41	Open treatment of rib fracture without fixation, each
21810		491.94	Treatment of rib fracture requiring external fixation (flail chest)
21820	01	164.53	Closed treatment of sternum fracture
21825		591.35	Open treatment of sternum fracture with or without skeletal fixation
21899		I.C.	Unlisted procedure, neck or thorax
21920		220.15	Biopsy, soft tissue of back or flank; superficial
21925	02	464.32	Biopsy, soft tissue of back or flank; deep
21930	02	436.87	Excision, tumor, soft tissue of back or flank
21935	03	1,173.88	Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank
22100		744.25	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical
22101		755.88	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; thoracic
22102		762.94	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; lumbar
22103		152.74	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure)
22110		949.90	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical
22112		946.37	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or

Code	Group	Fee	40.06(8) – Surgical Services Description
			nerve root(s), single vertebral segment; thoracic
22114		946.43	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar
22116		151.20	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)
22210		1,703.48	Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; cervical
22212		1,391.03	Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; thoracic
22214		1,413.66	Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; lumbar
22216		395.14	Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)
22220		1,517.97	Osteotomy of spine, including diskectomy, anterior approach, single vertebral segment; cervical
22222		1,411.04	Osteotomy of spine, including diskectomy, anterior approach, single vertebral segment; thoracic
22224		1,526.41	Osteotomy of spine, including diskectomy, anterior approach, single vertebral segment; lumbar
22226		395.07	Osteotomy of spine, including diskectomy, anterior approach, single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)
22305	01	222.27	Closed treatment of vertebral process fracture(s)
22310	01	317.63	Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing
22315	02	948.16	Closed treatment of vertebral fracture(s) and/or dislocation(s) requiring casting or bracing, with and including casting and/or bracing, with or without anesthesia, by manipulation or traction
22318		1,533.68	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; without grafting
22319		1,703.74	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; with grafting
22325		1,295.59	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; lumbar
22326		1,406.48	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; cervical
22327		1,346.85	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; thoracic
22328		293.57	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; each additional fractured vertebrae or dislocated segment (List separately in addition to code for primary procedure)
22505	02	120.04	Manipulation of spine requiring anesthesia, any region
22520		4,654.99	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic
22521		4,119.22	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar
22522		245.39	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)
22532		1,664.99	Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic
22533		1,554.11	Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); lumbar
22534		389.41	Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)

Code	Group	Fee	40.06(8) – Surgical Services Description
22548		1,819.67	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process
22554		1,347.20	Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); cervical below C2
22556		1,638.72	Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic
22558		1,512.31	Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); lumbar
22585		361.57	Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
22590		1,470.46	Arthrodesis, posterior technique, craniocervical (occiput-C2)
22595		1,400.67	Arthrodesis, posterior technique, atlas-axis (C1-C2)
22600		1,182.13	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment
22610		1,176.80	Arthrodesis, posterior or posterolateral technique, single level; thoracic (with or without lateral transverse technique)
22612		1,503.47	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)
22614		421.59	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)
22630		1,492.96	Arthrodesis, posterior interbody technique, including laminectomy and/or diskectomy to prepare interspace (other than for decompression), single interspace; lumbar
22632		342.08	Arthrodesis, posterior interbody technique, including laminectomy and/or diskectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)
22800		1,317.96	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments
22802		2,143.59	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments
22804		2,506.91	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments
22808		1,831.86	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments
22810		2,073.12	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments
22812		2,241.03	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments
22818		2,174.56	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments
22819		2,404.62	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments
22830		803.66	Exploration of spinal fusion
22840		820.02	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)
22841		I.C.	Internal spinal fixation by wiring of spinous processes
22842		822.67	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments
22843		862.17	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments
22844		1,076.87	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments

Code	Group	Fee	40.06(8) – Surgical Services Description
22845		788.18	Anterior instrumentation; 2 to 3 vertebral segments
22846		817.56	Anterior instrumentation; 4 to 7 vertebral segments
22847		902.71	Anterior instrumentation; 8 or more vertebral segments
22848		392.56	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum
22849		1,296.36	Reinsertion of spinal fixation device
22850		708.27	Removal of posterior nonsegmental instrumentation (eg, Harrington rod)
22851		434.90	Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace
22852		676.29	Removal of posterior segmental instrumentation
22855		1,078.49	Removal of anterior instrumentation
22899		I.C.	Unlisted procedure, spine
22900	04	377.60	Excision, abdominal wall tumor, subfascial (eg, desmoid)
22999		I.C.	Unlisted procedure, abdomen, musculoskeletal system
23000	02	400.39	Removal of subdeltoid calcareous deposits, open
23020	02	700.28	Capsular contracture release (eg, Sever type procedure)
23030	01	271.14	Incision and drainage, shoulder area; deep abscess or hematoma
23031	03	228.71	Incision and drainage, shoulder area; infected bursa
23035	03	726.22	Incision, bone cortex (eg, osteomyelitis or bone abscess), shoulder area
23040	03	723.64	Arthrotomy, glenohumeral joint, including exploration, drainage, or removal of foreign body
23044	04	577.20	Arthrotomy, acromioclavicular, sternoclavicular joint, including exploration, drainage, or removal of foreign body
23065		209.15	Biopsy, soft tissue of shoulder area; superficial
23066	02	389.47	Biopsy, soft tissue of shoulder area; deep
23075	02	193.55	Excision, soft tissue tumor, shoulder area; subcutaneous
23076	02	562.49	Excision, soft tissue tumor, shoulder area; deep, subfascial, or intramuscular
23077	03	1,124.95	Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area
23100	02	496.26	Arthrotomy, glenohumeral joint, including biopsy
23101	07	465.14	Arthrotomy, acromioclavicular joint or sternoclavicular joint, including biopsy and/or excision of torn cartilage
23105	04	653.00	Arthrotomy; glenohumeral joint, with synovectomy, with or without biopsy
23106	04	497.29	Arthrotomy; sternoclavicular joint, with synovectomy, with or without biopsy
23107	04	679.38	Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body
23120	05	576.58	Claviculectomy; partial
23125	05	721.23	Claviculectomy; total
23130	05	622.01	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release
23140	04	517.18	Excision or curettage of bone cyst or benign tumor of clavicle or scapula;
23145	05	706.91	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with autograft (includes obtaining graft)
23146	05	635.63	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with allograft
23150	04	654.30	Excision or curettage of bone cyst or benign tumor of proximal humerus;
23155	05	789.65	Excision or curettage of bone cyst or benign tumor of proximal humerus; with autograft (includes obtaining graft)

Code	Group	Fee	40.06(8) – Surgical Services Description
23156	05	680.62	Excision or curettage of bone cyst or benign tumor of proximal humerus; with allograft
23170	02	556.70	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle
23172	02	564.51	Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula
23174	02	758.15	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck
23180	04	752.11	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle
23182	04	720.69	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), scapula
23184	04	800.47	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), proximal humerus
23190	04	570.35	Ostectomy of scapula, partial (eg, superior medial angle)
23195	05	746.45	Resection, humeral head
23200		886.58	Radical resection for tumor; clavicle
23210		920.45	Radical resection for tumor; scapula
23220		1,079.98	Radical resection of bone tumor, proximal humerus;
23221		1,257.81	Radical resection of bone tumor, proximal humerus; with autograft (includes obtaining graft)
23222		1,690.40	Radical resection of bone tumor, proximal humerus; with prosthetic replacement
23330	01	159.83	Removal of foreign body, shoulder; subcutaneous
23331	01	601.03	Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)
23332		888.36	Removal of foreign body, shoulder; complicated (eg, total shoulder)
23350		201.80	Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography
23395	05	1,254.09	Muscle transfer, any type, shoulder or upper arm; single
23397	07	1,169.03	Muscle transfer, any type, shoulder or upper arm; multiple
23400	07	1,007.09	Scapulopexy (eg, Sprengels deformity or for paralysis)
23405	02	651.24	Tenotomy, shoulder area; single tendon
23406	02	814.33	Tenotomy, shoulder area; multiple tendons through same incision
23410	05	927.05	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute
23412	07	985.66	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic
23415	05	761.94	Coracoacromial ligament release, with or without acromioplasty
23420	07	1,022.38	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)
23430	04	768.51	Tenodesis of long tendon of biceps
23440	04	796.98	Resection or transplantation of long tendon of biceps
23450	05	987.79	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation
23455	07	1,054.21	Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)
23460	05	1,136.70	Capsulorrhaphy, anterior, any type; with bone block
23462	07	1,108.89	Capsulorrhaphy, anterior, any type; with coracoid process transfer
23465	05	1,131.47	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block
23466	07	1,082.82	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability
23470		1,243.58	Arthroplasty, glenohumeral joint; hemiarthroplasty
23472		1,481.85	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))
23480	04	846.91	Osteotomy, clavicle, with or without internal fixation;
23485	07	990.01	Osteotomy, clavicle, with or without internal fixation; with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)
23490	03	858.05	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate;

Code	Group	Fee	40.06(8) – Surgical Services Description
			clavicle
23491	03	1,058.42	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; proximal humerus
23500	01	242.02	Closed treatment of clavicular fracture; without manipulation
23505	01	381.45	Closed treatment of clavicular fracture; with manipulation
23515	03	591.08	Open treatment of clavicular fracture, with or without internal or external fixation
23520	01	244.61	Closed treatment of sternoclavicular dislocation; without manipulation
23525	01	373.42	Closed treatment of sternoclavicular dislocation; with manipulation
23530	03	560.36	Open treatment of sternoclavicular dislocation, acute or chronic;
23532	04	634.17	Open treatment of sternoclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)
23540	01	272.37	Closed treatment of acromioclavicular dislocation; without manipulation
23545	01	326.34	Closed treatment of acromioclavicular dislocation; with manipulation
23550	03	575.47	Open treatment of acromioclavicular dislocation, acute or chronic;
23552	04	666.89	Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)
23570	01	249.29	Closed treatment of scapular fracture; without manipulation
23575	01	414.72	Closed treatment of scapular fracture; with manipulation, with or without skeletal traction (with or without shoulder joint involvement)
23585	03	703.15	Open treatment of scapular fracture (body, glenoid or acromion) with or without internal fixation
23600	01	366.13	Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation
23605	02	485.35	Closed treatment of proximal humeral (surgical or anatomical neck) fracture; with manipulation, with or without skeletal traction
23615	04	765.91	Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(s);
23616	04	1,504.25	Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(s); with proximal humeral prosthetic replacement
23620	01	321.40	Closed treatment of greater humeral tuberosity fracture; without manipulation
23625	02	433.85	Closed treatment of greater humeral tuberosity fracture; with manipulation
23630	05	591.77	Open treatment of greater humeral tuberosity fracture, with or without internal or external fixation
23650	01	336.26	Closed treatment of shoulder dislocation, with manipulation; without anesthesia
23655	01	366.21	Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia
23660	03	586.75	Open treatment of acute shoulder dislocation
23665	02	467.15	Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation
23670	03	624.90	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with or without internal or external fixation
23675	02	576.44	Closed treatment of shoulder dislocation, with surgical or anatomical neck fracture, with manipulation
23680	03	770.01	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, with or without internal or external fixation
23700	01	204.58	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)
23800	04	1,045.52	Arthrodesis, glenohumeral joint;
23802	07	1,141.03	Arthrodesis, glenohumeral joint; with autogenous graft (includes obtaining graft)

Code	Group	Fee	40.06(8) – Surgical Services Description
23900		1,333.92	Interthoracoscapular amputation (forequarter)
23920		1,045.09	Disarticulation of shoulder;
23921	03	452.35	Disarticulation of shoulder; secondary closure or scar revision
23929		I.C.	Unlisted procedure, shoulder
23930	01	236.80	Incision and drainage, upper arm or elbow area; deep abscess or hematoma
23931	02	177.43	Incision and drainage, upper arm or elbow area; bursa
23935	02	517.97	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), humerus or elbow
24000	04	472.93	Arthrotomy, elbow, including exploration, drainage, or removal of foreign body
24006	04	720.75	Arthrotomy of the elbow, with capsular excision for capsular release (separate procedure)
24065		172.06	Biopsy, soft tissue of upper arm or elbow area; superficial
24066	02	461.09	Biopsy, soft tissue of upper arm or elbow area; deep (subfascial or intramuscular)
24075	02	375.92	Excision, tumor, soft tissue of upper arm or elbow area; subcutaneous
24076	02	476.95	Excision, tumor, soft tissue of upper arm or elbow area; deep (subfascial or intramuscular)
24077	03	855.03	Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area
24100	01	397.29	Arthrotomy, elbow; with synovial biopsy only
24101	04	508.09	Arthrotomy, elbow; with joint exploration, with or without biopsy, with or without removal of loose or foreign body
24102	04	629.63	Arthrotomy, elbow; with synovectomy
24105	03	336.82	Excision, olecranon bursa
24110	02	596.84	Excision or curettage of bone cyst or benign tumor, humerus;
24115	03	714.28	Excision or curettage of bone cyst or benign tumor, humerus; with autograft (includes obtaining graft)
24116	03	888.60	Excision or curettage of bone cyst or benign tumor, humerus; with allograft
24120	03	529.75	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process;
24125	03	589.45	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with autograft (includes obtaining graft)
24126	03	639.49	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with allograft
24130	03	517.61	Excision, radial head
24134	02	800.89	Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus
24136	02	644.17	Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck
24138	02	666.99	Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process
24140	03	790.22	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), humerus
24145	03	665.60	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck
24147	02	685.65	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), olecranon process
24149		1,084.37	Radical resection of capsule, soft tissue, and heterotopic bone, elbow, with contracture release (separate procedure)
24150		990.78	Radical resection for tumor, shaft or distal humerus;
24151		1,157.87	Radical resection for tumor, shaft or distal humerus; with autograft (includes obtaining graft)
24152		752.70	Radical resection for tumor, radial head or neck;
24153		703.27	Radical resection for tumor, radial head or neck; with autograft (includes obtaining graft)

Code	Group	Fee	40.06(8) – Surgical Services Description
24155	03	847.38	Resection of elbow joint (arthrectomy)
24160	02	618.96	Implant removal; elbow joint
24164	03	503.43	Implant removal; radial head
24200		154.81	Removal of foreign body, upper arm or elbow area; subcutaneous
24201	02	431.41	Removal of foreign body, upper arm or elbow area; deep (subfascial or intramuscular)
24220		486.83	Injection procedure for elbow arthrography
24300		389.73	Manipulation, elbow, under anesthesia
24301	04	775.79	Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)
24305	04	597.54	Tendon lengthening, upper arm or elbow, each tendon
24310	03	492.94	Tenotomy, open, elbow to shoulder, each tendon
24320	03	760.02	Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)
24330	03	736.75	Flexor-plasty, elbow (eg, Steindler type advancement);
24331	03	814.36	Flexor-plasty, elbow (eg, Steindler type advancement); with extensor advancement
24332		585.82	Tenolysis, triceps
24340	03	627.42	Tenodesis of biceps tendon at elbow (separate procedure)
24341	03	663.21	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)
24342	03	810.02	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
24343		700.88	Repair lateral collateral ligament, elbow, with local tissue
24344		1,070.22	Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24345	02	696.66	Repair medial collateral ligament, elbow, with local tissue
24346		1,064.32	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24350	03	456.38	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis);
24351	03	499.20	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with extensor origin detachment
24352	03	532.77	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with annular ligament resection
24354	03	532.07	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with stripping
24356	03	548.09	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with partial ostectomy
24360	05	919.90	Arthroplasty, elbow; with membrane (eg, fascial)
24361	05	1,040.76	Arthroplasty, elbow; with distal humeral prosthetic replacement
24362	05	1,054.36	Arthroplasty, elbow; with implant and fascia lata ligament reconstruction
24363	07	1,357.63	Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)
24365	05	655.06	Arthroplasty, radial head;
24366	05	703.30	Arthroplasty, radial head; with implant
24400	04	847.38	Osteotomy, humerus, with or without internal fixation
24410	04	1,066.14	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)
24420	03	1,021.40	Osteoplasty, humerus (eg, shortening or lengthening) (excluding 64876)
24430	03	958.38	Repair of nonunion or malunion, humerus; without graft (eg, compression technique)
24435	04	1,018.98	Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft)
24470	03	694.80	Hemiepiphyseal arrest (eg, cubitus varus or valgus, distal humerus)
24495	02	720.61	Decompression fasciotomy, forearm, with brachial artery exploration
24498	03	900.21	Prophylactic treatment (nailing, pinning, plating or wiring), with or without methylmethacrylate, humeral shaft

Code	Group	Fee	40.06(8) – Surgical Services Description
24500	01	363.37	Closed treatment of humeral shaft fracture; without manipulation
24505	01	527.97	Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction
24515	04	891.36	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage
24516	04	881.66	Treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws
24530	01	375.91	Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; without manipulation
24535	01	647.15	Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; with manipulation, with or without skin or skeletal traction
24538	02	766.83	Percutaneous skeletal fixation of supracondylar or transcondylar humeral fracture, with or without intercondylar extension
24545	04	801.70	Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; without intercondylar extension
24546	05	1,146.54	Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; with intercondylar extension
24560	01	331.90	Closed treatment of humeral epicondylar fracture, medial or lateral; without manipulation
24565	02	542.86	Closed treatment of humeral epicondylar fracture, medial or lateral; with manipulation
24566	02	675.13	Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation
24575	03	803.29	Open treatment of humeral epicondylar fracture, medial or lateral, with or without internal or external fixation
24576	01	329.88	Closed treatment of humeral condylar fracture, medial or lateral; without manipulation
24577	01	566.03	Closed treatment of humeral condylar fracture, medial or lateral; with manipulation
24579	03	867.37	Open treatment of humeral condylar fracture, medial or lateral, with or without internal or external fixation
24582	02	745.33	Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation
24586	04	1,117.91	Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius);
24587	05	1,108.19	Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius); with implant arthroplasty
24600	01	411.63	Treatment of closed elbow dislocation; without anesthesia
24605	02	451.41	Treatment of closed elbow dislocation; requiring anesthesia
24615	03	728.08	Open treatment of acute or chronic elbow dislocation
24620	02	553.08	Closed treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with manipulation
24635	03	1,162.22	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with or without internal or external fixation
24640		130.51	Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation
24650		283.45	Closed treatment of radial head or neck fracture; without manipulation
24655	01	471.50	Closed treatment of radial head or neck fracture; with manipulation
24665	04	662.68	Open treatment of radial head or neck fracture, with or without internal fixation or radial head excision;
24666	04	744.51	Open treatment of radial head or neck fracture, with or without internal fixation or radial head excision; with radial head prosthetic replacement
24670	01	294.94	Closed treatment of ulnar fracture, proximal end (olecranon process); without manipulation
24675	01	484.28	Closed treatment of ulnar fracture, proximal end (olecranon process); with manipulation
24685	03	692.85	Open treatment of ulnar fracture proximal end (olecranon process), with or without internal or

Code	Group	Fee	40.06(8) – Surgical Services Description
			external fixation
24800	04	839.74	Arthrodesis, elbow joint; local
24802	05	1,018.89	Arthrodesis, elbow joint; with autogenous graft (includes obtaining graft)
24900		714.05	Amputation, arm through humerus; with primary closure
24920		720.45	Amputation, arm through humerus; open, circular (guillotine)
24925	03	565.02	Amputation, arm through humerus; secondary closure or scar revision
24930		747.15	Amputation, arm through humerus; re-amputation
24931		792.85	Amputation, arm through humerus; with implant
24935		998.23	Stump elongation, upper extremity
24940		I.C.	Cineplasty, upper extremity, complete procedure
24999		I.C.	Unlisted procedure, humerus or elbow
25000	03	436.25	Incision, extensor tendon sheath, wrist (eg, deQuervains disease)
25001		315.69	Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)
25020	03	669.46	Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; without debridement of nonviable muscle and/or nerve
25023	03	1,194.12	Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; with debridement of nonviable muscle and/or nerve
25024	03	719.85	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve
25025	03	1,123.37	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve
25028	01	577.26	Incision and drainage, forearm and/or wrist; deep abscess or hematoma
25031	02	521.50	Incision and drainage, forearm and/or wrist; bursa
25035	02	903.97	Incision, deep, bone cortex, forearm and/or wrist (eg, osteomyelitis or bone abscess)
25040	05	614.58	Arthrotomy, radiocarpal or midcarpal joint, with exploration, drainage, or removal of foreign body
25065		196.85	Biopsy, soft tissue of forearm and/or wrist; superficial
25066	02	478.25	Biopsy, soft tissue of forearm and/or wrist; deep (subfascial or intramuscular)
25075	02	413.46	Excision, tumor, soft tissue of forearm and/or wrist area; subcutaneous
25076	03	627.14	Excision, tumor, soft tissue of forearm and/or wrist area; deep (subfascial or intramuscular)
25077	03	942.07	Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area
25085	03	540.54	Capsulotomy, wrist (eg, contracture)
25100	02	392.74	Arthrotomy, wrist joint; with biopsy
25101	03	449.31	Arthrotomy, wrist joint; with joint exploration, with or without biopsy, with or without removal of loose or foreign body
25105	04	563.43	Arthrotomy, wrist joint; with synovectomy
25107	03	626.30	Arthrotomy, distal radioulnar joint including repair of triangular cartilage, complex
25110	03	470.88	Excision, lesion of tendon sheath, forearm and/or wrist
25111	03	346.36	Excision of ganglion, wrist (dorsal or volar); primary
25112	04	418.84	Excision of ganglion, wrist (dorsal or volar); recurrent
25115	04	981.11	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors
25116	04	870.77	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum

Code	Group	Fee	40.06(8) – Surgical Services Description
25118	02	432.07	Synovectomy, extensor tendon sheath, wrist, single compartment;
25119	03	583.71	Synovectomy, extensor tendon sheath, wrist, single compartment; with resection of distal ulna
25120	03	783.44	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process);
25125	03	875.43	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with autograft (includes obtaining graft)
25126	03	881.69	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with allograft
25130	03	496.39	Excision or curettage of bone cyst or benign tumor of carpal bones;
25135	03	608.95	Excision or curettage of bone cyst or benign tumor of carpal bones; with autograft (includes obtaining graft)
25136	03	527.33	Excision or curettage of bone cyst or benign tumor of carpal bones; with allograft
25145	02	795.18	Sequestrectomy (eg, for osteomyelitis or bone abscess), forearm and/or wrist
25150	02	656.29	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); ulna
25151	02	863.26	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); radius
25170		1,124.02	Radical resection for tumor, radius or ulna
25210	03	541.25	Carpectomy; one bone
25215	04	708.79	Carpectomy; all bones of proximal row
25230	04	483.03	Radial styloidectomy (separate procedure)
25240	04	518.34	Excision distal ulna partial or complete (eg, Darrach type or matched resection)
25246		480.73	Injection procedure for wrist arthrography
25248	02	581.79	Exploration with removal of deep foreign body, forearm or wrist
25250	01	531.72	Removal of wrist prosthesis; (separate procedure)
25251	01	731.83	Removal of wrist prosthesis; complicated, including total wrist
25259		390.03	Manipulation, wrist, under anesthesia
25260	04	914.79	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle
25263	02	910.55	Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, single, each tendon or muscle
25265	03	1,035.04	Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle
25270	04	784.61	Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle
25272	03	857.83	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, single, each tendon or muscle
25274	04	961.67	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle
25275	04	675.83	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)
25280	04	854.14	Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon
25290	03	877.75	Tenotomy, open, flexor or extensor tendon, forearm and/or wrist, single, each tendon
25295	03	808.53	Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon
25300	03	729.31	Tenodesis at wrist; flexors of fingers
25301	03	699.35	Tenodesis at wrist; extensors of fingers
25310	03	909.72	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon
25312	04	1,008.23	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; with tendon graft(s) (includes obtaining graft), each tendon
25315	03	1,057.14	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist;

Code	Group	Fee	40.06(8) – Surgical Services Description
25316	03	1,229.47	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist; with tendon(s) transfer
25320	03	925.61	Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability
25332	05	864.21	Arthroplasty, wrist, with or without interposition, with or without external or internal fixation
25335	03	1,038.97	Centralization of wrist on ulna (eg, radial club hand)
25337	05	896.78	Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint, secondary by soft tissue stabilization (eg, tendon transfer, tendon graft or weave, or tenodesis) with or without open reduction of distal radioulnar joint
25350	03	974.96	Osteotomy, radius; distal third
25355	03	1,063.03	Osteotomy, radius; middle or proximal third
25360	03	957.12	Osteotomy; ulna
25365	03	1,198.64	Osteotomy; radius AND ulna
25370	03	1,258.23	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna
25375	04	1,262.37	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna
25390	03	1,069.72	Osteoplasty, radius OR ulna; shortening
25391	04	1,287.80	Osteoplasty, radius OR ulna; lengthening with autograft
25392	03	1,272.55	Osteoplasty, radius AND ulna; shortening (excluding 64876)
25393	04	1,419.19	Osteoplasty, radius AND ulna; lengthening with autograft
25394		789.03	Osteoplasty, carpal bone, shortening
25400	03	1,118.28	Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)
25405	04	1,353.05	Repair of nonunion or malunion, radius OR ulna; with autograft (includes obtaining graft)
25415	03	1,279.05	Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)
25420	04	1,476.89	Repair of nonunion or malunion, radius AND ulna; with autograft (includes obtaining graft)
25425	03	1,486.33	Repair of defect with autograft; radius OR ulna
25426	04	1,405.32	Repair of defect with autograft; radius AND ulna
25430		694.00	Insertion of vascular pedicle into carpal bone (eg, Hori procedure)
25431		760.26	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone
25440	04	840.58	Repair of nonunion, scaphoid carpal (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)
25441	05	968.46	Arthroplasty with prosthetic replacement; distal radius
25442	05	823.07	Arthroplasty with prosthetic replacement; distal ulna
25443	05	802.76	Arthroplasty with prosthetic replacement; scaphoid carpal (navicular)
25444	05	853.63	Arthroplasty with prosthetic replacement; lunate
25445	05	742.36	Arthroplasty with prosthetic replacement; trapezium
25446	07	1,200.65	Arthroplasty with prosthetic replacement; distal radius and partial or entire carpus (total wrist)
25447	05	798.87	Arthroplasty, interposition, intercarpal or carpometacarpal joints
25449	05	1,055.10	Revision of arthroplasty, including removal of implant, wrist joint
25450	03	767.01	Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna
25455	03	873.78	Epiphyseal arrest by epiphysiodesis or stapling; distal radius AND ulna
25490	03	993.98	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius

Code	Group	Fee	40.06(8) – Surgical Services Description
25491	03	1,049.65	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; ulna
25492	03	1,179.44	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius AND ulna
25500		270.78	Closed treatment of radial shaft fracture; without manipulation
25505	01	525.33	Closed treatment of radial shaft fracture; with manipulation
25515	03	704.77	Open treatment of radial shaft fracture, with or without internal or external fixation
25520	01	580.20	Closed treatment of radial shaft fracture and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation)
25525	04	940.70	Open treatment of radial shaft fracture, with internal and/ or external fixation and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with or without percutaneous skeletal fixation
25526	05	1,126.66	Open treatment of radial shaft fracture, with internal and/or external fixation and open treatment, with or without internal or external fixation of distal radioulnar joint (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex
25530		263.23	Closed treatment of ulnar shaft fracture; without manipulation
25535	01	506.80	Closed treatment of ulnar shaft fracture; with manipulation
25545	03	702.10	Open treatment of ulnar shaft fracture, with or without internal or external fixation
25560		272.21	Closed treatment of radial and ulnar shaft fractures; without manipulation
25565	02	549.35	Closed treatment of radial and ulnar shaft fractures; with manipulation
25574	03	599.31	Open treatment of radial AND ulnar shaft fractures, with internal or external fixation; of radius OR ulna
25575	03	841.92	Open treatment of radial AND ulnar shaft fractures, with internal or external fixation; of radius AND ulna
25600		299.90	Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation
25605	03	586.60	Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; with manipulation
25611	03	704.25	Percutaneous skeletal fixation of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation, with or without external fixation
25620	05	671.21	Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation
25622		306.01	Closed treatment of carpal scaphoid (navicular) fracture; without manipulation
25624	02	486.87	Closed treatment of carpal scaphoid (navicular) fracture; with manipulation
25628	03	687.82	Open treatment of carpal scaphoid (navicular) fracture, with or without internal or external fixation
25630		314.74	Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); without manipulation, each bone
25635	01	463.80	Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); with manipulation, each bone
25645	03	592.83	Open treatment of carpal bone fracture (other than carpal scaphoid (navicular)), each bone
25650		332.11	Closed treatment of ulnar styloid fracture
25651		455.05	Percutaneous skeletal fixation of ulnar styloid fracture
25652		611.86	Open treatment of ulnar styloid fracture
25660	01	396.85	Closed treatment of radiocarpal or intercarpal dislocation, one or more bones, with manipulation
25670	03	635.42	Open treatment of radiocarpal or intercarpal dislocation, one or more bones
25671	01	507.35	Percutaneous skeletal fixation of distal radioulnar dislocation

Code	Group	Fee	40.06(8) – Surgical Services Description
25675	01	470.00	Closed treatment of distal radioulnar dislocation with manipulation
25676	02	651.26	Open treatment of distal radioulnar dislocation, acute or chronic
25680	02	447.93	Closed treatment of trans-scaphoperilunar type of fracture dislocation, with manipulation
25685	03	745.46	Open treatment of trans-scaphoperilunar type of fracture dislocation
25690	01	462.42	Closed treatment of lunate dislocation, with manipulation
25695	02	655.89	Open treatment of lunate dislocation
25800	04	798.35	Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints)
25805	05	910.85	Arthrodesis, wrist; with sliding graft
25810	05	863.80	Arthrodesis, wrist; with iliac or other autograft (includes obtaining graft)
25820	04	647.52	Arthrodesis, wrist; limited, without bone graft (eg, intercarpal or radiocarpal)
25825	05	781.33	Arthrodesis, wrist; with autograft (includes obtaining graft)
25830	05	1,043.73	Arthrodesis, distal radioulnar joint with segmental resection of ulna, with or without bone graft (eg, Sauve-Kapandji procedure)
25900		921.74	Amputation, forearm, through radius and ulna;
25905		922.34	Amputation, forearm, through radius and ulna; open, circular (guillotine)
25907	03	845.04	Amputation, forearm, through radius and ulna; secondary closure or scar revision
25909		914.07	Amputation, forearm, through radius and ulna; re-amputation
25915		1,552.64	Krukenberg procedure
25920		702.56	Disarticulation through wrist;
25922	03	618.63	Disarticulation through wrist; secondary closure or scar revision
25924		703.84	Disarticulation through wrist; re-amputation
25927		880.53	Transmetacarpal amputation;
25929	03	573.38	Transmetacarpal amputation; secondary closure or scar revision
25931		834.30	Transmetacarpal amputation; re-amputation
25999		I.C.	Unlisted procedure, forearm or wrist
26010		302.18	Drainage of finger abscess; simple
26011	01	474.34	Drainage of finger abscess; complicated (eg, felon)
26020	02	431.82	Drainage of tendon sheath, digit and/or palm, each
26025	01	428.92	Drainage of palmar bursa; single, bursa
26030	02	502.26	Drainage of palmar bursa; multiple bursa
26034	02	527.35	Incision, bone cortex, hand or finger (eg, osteomyelitis or bone abscess)
26035		740.17	Decompression fingers and/or hand, injection injury (eg, grease gun)
26037		582.72	Decompressive fasciotomy, hand (excludes 26035)
26040	04	309.96	Fasciotomy, palmar (eg, Dupuytren's contracture); percutaneous
26045	03	470.35	Fasciotomy, palmar (eg, Dupuytren's contracture); open, partial
26055	02	727.25	Tendon sheath incision (eg, for trigger finger)
26060	02	263.99	Tenotomy, percutaneous, single, each digit
26070	02	293.01	Arthrotomy, with exploration, drainage, or removal of loose or foreign body; carpometacarpal joint
26075	04	315.44	Arthrotomy, with exploration, drainage, or removal of loose or foreign body; metacarpophalangeal joint, each
26080	04	379.90	Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each

Code	Group	Fee	40.06(8) – Surgical Services Description
26100	02	327.04	Arthrotomy with biopsy; carpometacarpal joint, each
26105	01	331.50	Arthrotomy with biopsy; metacarpophalangeal joint, each
26110	01	316.40	Arthrotomy with biopsy; interphalangeal joint, each
26115	02	724.49	Excision, tumor or vascular malformation, soft tissue of hand or finger; subcutaneous
26116	02	482.60	Excision, tumor or vascular malformation, soft tissue of hand or finger; deep (subfascial or intramuscular)
26117	03	654.97	Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger
26121	04	608.70	Fasciectomy, palm only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)
26123	04	760.66	Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft);
26125	04	297.86	Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft); each additional digit (List separately in addition to code for primary procedure)
26130	03	450.82	Synovectomy, carpometacarpal joint
26135	04	562.93	Synovectomy, metacarpophalangeal joint including intrinsic release and extensor hood reconstruction, each digit
26140	02	511.54	Synovectomy, proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint
26145	03	517.92	Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, each tendon
26160	03	667.81	Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger
26170	03	406.80	Excision of tendon, palm, flexor, single (separate procedure), each
26180	03	443.57	Excision of tendon, finger, flexor (separate procedure), each tendon
26185	04	471.02	Sesamoidectomy, thumb or finger (separate procedure)
26200	02	456.19	Excision or curettage of bone cyst or benign tumor of metacarpal;
26205	03	612.81	Excision or curettage of bone cyst or benign tumor of metacarpal; with autograft (includes obtaining graft)
26210	02	442.86	Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger;
26215	03	559.14	Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger; with autograft (includes obtaining graft)
26230	07	515.21	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); metacarpal
26235	03	503.62	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); proximal or middle phalanx of finger
26236	03	446.80	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); distal phalanx of finger
26250	03	586.56	Radical resection, metacarpal (eg, tumor);
26255	03	900.21	Radical resection, metacarpal (eg, tumor); with autograft (includes obtaining graft)
26260	03	553.54	Radical resection, proximal or middle phalanx of finger (eg, tumor);
26261	03	635.31	Radical resection, proximal or middle phalanx of finger (eg, tumor); with autograft (includes obtaining graft)
26262	02	461.62	Radical resection, distal phalanx of finger (eg, tumor)
26320	02	346.56	Removal of implant from finger or hand
26340		304.88	Manipulation, finger joint, under anesthesia, each joint
26350	01	904.86	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); primary or secondary without free graft, each tendon

Code	Group	Fee	40.06(8) – Surgical Services Description
26352	04	1,000.66	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); secondary with free graft (includes obtaining graft), each tendon
26356	04	1,136.76	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon
26357	04	1,056.86	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, without free graft, each tendon
26358	04	1,117.72	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, with free graft (includes obtaining graft), each tendon
26370	04	972.78	Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon
26372	04	1,098.45	Repair or advancement of profundus tendon, with intact superficialis tendon; secondary with free graft (includes obtaining graft), each tendon
26373	03	1,053.86	Repair or advancement of profundus tendon, with intact superficialis tendon; secondary without free graft, each tendon
26390	04	972.24	Excision flexor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod
26392	03	1,176.17	Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod
26410	03	725.63	Repair, extensor tendon, hand, primary or secondary; without free graft, each tendon
26412	03	853.14	Repair, extensor tendon, hand, primary or secondary; with free graft (includes obtaining graft), each tendon
26415	04	859.66	Excision of extensor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod
26416	03	1,037.61	Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod
26418	04	723.78	Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon
26420	04	886.02	Repair, extensor tendon, finger, primary or secondary; with free graft (includes obtaining graft) each tendon
26426	03	840.31	Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); using local tissue(s), including lateral band(s), each finger
26428	03	916.40	Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); with free graft (includes obtaining graft), each finger
26432	03	619.24	Closed treatment of distal extensor tendon insertion, with or without percutaneous pinning (eg, mallet finger)
26433	03	671.26	Repair of extensor tendon, distal insertion, primary or secondary; without graft (eg, mallet finger)
26434	03	763.44	Repair of extensor tendon, distal insertion, primary or secondary; with free graft (includes obtaining graft)
26437	03	750.79	Realignment of extensor tendon, hand, each tendon
26440	03	809.16	Tenolysis, flexor tendon; palm OR finger, each tendon
26442	03	1,041.40	Tenolysis, flexor tendon; palm AND finger, each tendon
26445	03	768.85	Tenolysis, extensor tendon, hand OR finger; each tendon
26449	03	984.78	Tenolysis, complex, extensor tendon, finger, including forearm, each tendon
26450	03	474.04	Tenotomy, flexor, palm, open, each tendon
26455	03	470.13	Tenotomy, flexor, finger, open, each tendon
26460	03	454.56	Tenotomy, extensor, hand or finger, open, each tendon
26471	02	733.18	Tenodesis; of proximal interphalangeal joint, each joint
26474	02	724.23	Tenodesis; of distal joint, each joint
26476	01	696.74	Lengthening of tendon, extensor, hand or finger, each tendon

Code	Group	Fee	40.06(8) – Surgical Services Description
26477	01	701.88	Shortening of tendon, extensor, hand or finger, each tendon
26478	01	762.19	Lengthening of tendon, flexor, hand or finger, each tendon
26479	01	752.89	Shortening of tendon, flexor, hand or finger, each tendon
26480	03	943.16	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon
26483	03	1,028.94	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; with free tendon graft (includes obtaining graft), each tendon
26485	02	998.76	Transfer or transplant of tendon, palmar; without free tendon graft, each tendon
26489	03	923.75	Transfer or transplant of tendon, palmar; with free tendon graft (includes obtaining graft), each tendon
26490	03	909.59	Opponensplasty; superficialis tendon transfer type, each tendon
26492	03	994.46	Opponensplasty; tendon transfer with graft (includes obtaining graft), each tendon
26494	03	933.52	Opponensplasty; hypothenar muscle transfer
26496	03	977.26	Opponensplasty; other methods
26497	03	991.26	Transfer of tendon to restore intrinsic function; ring and small finger
26498	04	1,287.81	Transfer of tendon to restore intrinsic function; all four fingers
26499	03	941.22	Correction claw finger, other methods
26500	04	759.27	Reconstruction of tendon pulley, each tendon; with local tissues (separate procedure)
26502	04	830.66	Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure)
26504	04	860.03	Reconstruction of tendon pulley, each tendon; with tendon prosthesis (separate procedure)
26508	03	764.33	Release of thenar muscle(s) (eg, thumb contracture)
26510	03	727.17	Cross intrinsic transfer, each tendon
26516	01	835.18	Capsulodesis, metacarpophalangeal joint; single digit
26517	03	955.86	Capsulodesis, metacarpophalangeal joint; two digits
26518	03	961.01	Capsulodesis, metacarpophalangeal joint; three or four digits
26520	03	839.59	Capsulectomy or capsulotomy; metacarpophalangeal joint, each joint
26525	03	845.96	Capsulectomy or capsulotomy; interphalangeal joint, each joint
26530	03	536.86	Arthroplasty, metacarpophalangeal joint; each joint
26531	07	629.15	Arthroplasty, metacarpophalangeal joint; with prosthetic implant, each joint
26535	05	376.76	Arthroplasty, interphalangeal joint; each joint
26536	05	679.20	Arthroplasty, interphalangeal joint; with prosthetic implant, each joint
26540	04	792.09	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint
26541	07	948.15	Reconstruction, collateral ligament, metacarpophalangeal joint, single; with tendon or fascial graft (includes obtaining graft)
26542	04	809.07	Reconstruction, collateral ligament, metacarpophalangeal joint, single; with local tissue (eg, adductor advancement)
26545	04	828.21	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint
26546	04	1,017.82	Repair non-union, metacarpal or phalanx, (includes obtaining bone graft with or without external or internal fixation)
26548	04	902.26	Repair and reconstruction, finger, volar plate, interphalangeal joint
26550	02	1,630.42	Pollicization of a digit
26551		3,412.39	Transfer, toe-to-hand with microvascular anastomosis; great toe wrap-around with bone graft
26553		2,793.01	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, single
26554		3,952.51	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, double

Code	Group	Fee	40.06(8) – Surgical Services Description
26555	03	1,490.44	Transfer, finger to another position without microvascular anastomosis
26556		3,474.94	Transfer, free toe joint, with microvascular anastomosis
26560	02	657.44	Repair of syndactyly (web finger) each web space; with skin flaps
26561	03	980.98	Repair of syndactyly (web finger) each web space; with skin flaps and grafts
26562	04	1,341.77	Repair of syndactyly (web finger) each web space; complex (eg, involving bone, nails)
26565	05	809.31	Osteotomy; metacarpal, each
26567	05	809.38	Osteotomy; phalanx of finger, each
26568	03	1,060.17	Osteoplasty, lengthening, metacarpal or phalanx
26580	05	1,326.53	Repair cleft hand
26587	05	951.05	Reconstruction of polydactylous digit, soft tissue and bone
26590	05	1,330.84	Repair macrodactylia, each digit
26591	03	576.14	Repair, intrinsic muscles of hand, each muscle
26593	03	708.14	Release, intrinsic muscles of hand, each muscle
26596	02	748.42	Excision of constricting ring of finger, with multiple Z-plasties
26600		254.90	Closed treatment of metacarpal fracture, single; without manipulation, each bone
26605	02	342.58	Closed treatment of metacarpal fracture, single; with manipulation, each bone
26607	02	494.61	Closed treatment of metacarpal fracture, with manipulation, with external fixation, each bone
26608	04	495.81	Percutaneous skeletal fixation of metacarpal fracture, each bone
26615	04	458.92	Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone
26641		391.13	Closed treatment of carpometacarpal dislocation, thumb, with manipulation
26645	01	442.55	Closed treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation
26650	02	528.17	Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, with or without external fixation
26665	04	607.95	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external fixation
26670		357.80	Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; without anesthesia
26675	02	457.61	Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; requiring anesthesia
26676	02	521.59	Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb, with manipulation, each joint
26685	03	561.21	Open treatment of carpometacarpal dislocation, other than thumb; with or without internal or external fixation, each joint
26686	03	633.47	Open treatment of carpometacarpal dislocation, other than thumb; complex, multiple or delayed reduction
26700		347.38	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia
26705	02	429.81	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; requiring anesthesia
26706	02	430.35	Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation
26715	04	483.77	Open treatment of metacarpophalangeal dislocation, single, with or without internal or external fixation
26720		233.77	Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each
26725		397.88	Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; with manipulation, with or without skin or skeletal traction, each

Code	Group	Fee	40.06(8) – Surgical Services Description
26727	07	491.52	Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each
26735	04	500.04	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external fixation, each
26740		231.92	Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; without manipulation, each
26742	02	407.41	Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; with manipulation, each
26746	05	494.54	Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, with or without internal or external fixation, each
26750		203.37	Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each
26755		333.16	Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each
26756	02	440.17	Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each
26765	04	376.96	Open treatment of distal phalangeal fracture, finger or thumb, with or without internal or external fixation, each
26770		309.26	Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia
26775		401.72	Closed treatment of interphalangeal joint dislocation, single, with manipulation; requiring anesthesia
26776	02	465.20	Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulation
26785	02	380.63	Open treatment of interphalangeal joint dislocation, with or without internal or external fixation, single
26820	05	925.85	Fusion in opposition, thumb, with autogenous graft (includes obtaining graft)
26841	04	873.92	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation;
26842	04	928.17	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation; with autograft (includes obtaining graft)
26843	03	856.79	Arthrodesis, carpometacarpal joint, digit, other than thumb, each;
26844	03	945.98	Arthrodesis, carpometacarpal joint, digit, other than thumb, each; with autograft (includes obtaining graft)
26850	04	824.00	Arthrodesis, metacarpophalangeal joint, with or without internal fixation;
26852	04	915.27	Arthrodesis, metacarpophalangeal joint, with or without internal fixation; with autograft (includes obtaining graft)
26860	03	684.95	Arthrodesis, interphalangeal joint, with or without internal fixation;
26861	02	112.92	Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint (List separately in addition to code for primary procedure)
26862	04	848.29	Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft)
26863	03	254.65	Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft), each additional joint (List separately in addition to code for primary procedure)
26910	03	812.11	Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseous transfer
26951	02	640.78	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure
26952	04	779.80	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with local advancement flaps (V-Y, hood)
26989		I.C.	Unlisted procedure, hands or fingers
26990	01	636.61	Incision and drainage, pelvis or hip joint area; deep abscess or hematoma
26991	01	597.30	Incision and drainage, pelvis or hip joint area; infected bursa

Code	Group	Fee	40.06(8) – Surgical Services Description
26992		1,011.29	Incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess)
27000	02	462.14	Tenotomy, adductor of hip, percutaneous (separate procedure)
27001	03	555.06	Tenotomy, adductor of hip, open
27003	03	586.11	Tenotomy, adductor, subcutaneous, open, with obturator neurectomy
27005		743.99	Tenotomy, hip flexor(s), open (separate procedure)
27006		749.44	Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)
27025		832.39	Fasciotomy, hip or thigh, any type
27030		962.43	Arthrotomy, hip, with drainage (eg, infection)
27033	03	990.54	Arthrotomy, hip, including exploration or removal of loose or foreign body
27035	04	1,209.48	Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral, or obturator nerves
27036		972.83	Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)
27040	01	226.17	Biopsy, soft tissue of pelvis and hip area; superficial
27041	02	692.86	Biopsy, soft tissue of pelvis and hip area; deep, subfascial or intramuscular
27047	02	585.16	Excision, tumor, pelvis and hip area; subcutaneous tissue
27048	03	474.16	Excision, tumor, pelvis and hip area; deep, subfascial, intramuscular
27049	03	943.62	Radical resection of tumor, soft tissue of pelvis and hip area (eg, malignant neoplasm)
27050	03	372.08	Arthrotomy, with biopsy; sacroiliac joint
27052	03	513.73	Arthrotomy, with biopsy; hip joint
27054		674.20	Arthrotomy with synovectomy, hip joint
27060	05	430.00	Excision; ischial bursa
27062	05	448.86	Excision; trochanteric bursa or calcification
27065	05	483.23	Excision of bone cyst or benign tumor; superficial (wing of ilium, symphysis pubis, or greater trochanter of femur) with or without autograft
27066	05	798.80	Excision of bone cyst or benign tumor; deep, with or without autograft
27067	05	1,041.03	Excision of bone cyst or benign tumor; with autograft requiring separate incision
27070		864.94	Partial excision (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial (eg, wing of ilium, symphysis pubis, or greater trochanter of femur)
27071		939.13	Partial excision (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)
27075		2,227.93	Radical resection of tumor or infection; wing of ilium, one pubic or ischial ramus or symphysis pubis
27076		1,559.93	Radical resection of tumor or infection; ilium, including acetabulum, both pubic rami, or ischium and acetabulum
27077		2,595.05	Radical resection of tumor or infection; innominate bone, total
27078		1,006.01	Radical resection of tumor or infection; ischial tuberosity and greater trochanter of femur
27079		1,010.26	Radical resection of tumor or infection; ischial tuberosity and greater trochanter of femur, with skin flaps
27080	02	483.52	Coccygectomy, primary
27086	01	161.54	Removal of foreign body, pelvis or hip; subcutaneous tissue
27087	03	643.80	Removal of foreign body, pelvis or hip; deep (subfascial or intramuscular)
27090		840.42	Removal of hip prosthesis; (separate procedure)
27091		1,530.47	Removal of hip prosthesis; complicated, including total hip prosthesis, methylmethacrylate with or

Code	Group	Fee	40.06(8) – Surgical Services Description
			without insertion of spacer
27093		567.02	Injection procedure for hip arthrography; without anesthesia
27095		513.74	Injection procedure for hip arthrography; with anesthesia
27096		449.93	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid
27097	03	648.29	Release or recession, hamstring, proximal
27098	03	676.87	Transfer, adductor to ischium
27100	04	841.75	Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft)
27105	04	890.88	Transfer paraspinal muscle to hip (includes fascial or tendon extension graft)
27110	04	942.36	Transfer iliopsoas; to greater trochanter of femur
27111	04	898.07	Transfer iliopsoas; to femoral neck
27120		1,261.37	Acetabuloplasty; (eg, Whitman, Colonna, Haygroves, or cup type)
27122		1,099.31	Acetabuloplasty; resection, femoral head (eg, Girdlestone procedure)
27125		1,069.47	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)
27130		1,416.40	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
27132		1,647.90	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft
27134		1,963.32	Revision of total hip arthroplasty; both components, with or without autograft or allograft
27137		1,487.11	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft
27138		1,549.31	Revision of total hip arthroplasty; femoral component only, with or without allograft
27140		917.76	Osteotomy and transfer of greater trochanter of femur (separate procedure)
27146		1,255.55	Osteotomy, iliac, acetabular or innominate bone;
27147		1,431.73	Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip
27151		1,306.55	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy
27156		1,731.91	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip
27158		1,311.23	Osteotomy, pelvis, bilateral (eg, congenital malformation)
27161		1,222.61	Osteotomy, femoral neck (separate procedure)
27165		1,306.79	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast
27170		1,161.05	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)
27175		639.20	Treatment of slipped femoral epiphysis; by traction, without reduction
27176		893.07	Treatment of slipped femoral epiphysis; by single or multiple pinning, in situ
27177		1,100.61	Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft)
27178		866.35	Open treatment of slipped femoral epiphysis; closed manipulation with single or multiple pinning
27179		973.46	Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (Heyman type procedure)
27181		1,043.66	Open treatment of slipped femoral epiphysis; osteotomy and internal fixation
27185		712.11	Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur
27187		1,013.66	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and proximal femur
27193	01	536.47	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation

Code	Group	Fee	40.06(8) – Surgical Services Description
27194	02	780.05	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia
27200		205.63	Closed treatment of coccygeal fracture
27202	02	1,034.01	Open treatment of coccygeal fracture
27215		729.95	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s) (eg, pelvic fracture(s) which do not disrupt the pelvic ring), with internal fixation
27216		1,059.46	Percutaneous skeletal fixation of posterior pelvic ring fracture and/or dislocation (includes ilium, sacroiliac joint and/or sacrum)
27217		1,029.66	Open treatment of anterior ring fracture and/or dislocation with internal fixation (includes pubic symphysis and/or rami)
27218		1,346.65	Open treatment of posterior ring fracture and/or dislocation with internal fixation (includes ilium, sacroiliac joint and/or sacrum)
27220		561.16	Closed treatment of acetabulum (hip socket) fracture(s); without manipulation
27222		958.51	Closed treatment of acetabulum (hip socket) fracture(s); with manipulation, with or without skeletal traction
27226		970.33	Open treatment of posterior or anterior acetabular wall fracture, with internal fixation
27227		1,647.10	Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation
27228		1,899.78	Open treatment of acetabular fracture(s) involving anterior and posterior (two) columns, includes T-fracture and both column fracture with complete articular detachment, or single column or transverse fracture with associated acetabular wall fracture, with internal fixation
27230	01	507.84	Closed treatment of femoral fracture, proximal end, neck; without manipulation
27232		757.13	Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction
27235		915.40	Percutaneous skeletal fixation of femoral fracture, proximal end, neck
27236		1,127.13	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement
27238	01	449.93	Closed treatment of intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture; without manipulation
27240		926.78	Closed treatment of intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction
27244		1,155.66	Treatment of intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage
27245		1,445.42	Treatment of intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage
27246	01	439.82	Closed treatment of greater trochanteric fracture, without manipulation
27248		791.03	Open treatment of greater trochanteric fracture, with or without internal or external fixation
27250	01	487.37	Closed treatment of hip dislocation, traumatic; without anesthesia
27252	02	752.05	Closed treatment of hip dislocation, traumatic; requiring anesthesia
27253		961.57	Open treatment of hip dislocation, traumatic, without internal fixation
27254		1,285.72	Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation
27256		317.27	Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; without anesthesia, without manipulation
27257	03	338.26	Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction, splint or traction; with manipulation, requiring anesthesia
27258		1,115.38	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological),

Code	Group	Fee	40.06(8) – Surgical Services Description
			replacement of femoral head in acetabulum (including tenotomy, etc);
27259		1,516.67	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc); with femoral shaft shortening
27265	01	414.10	Closed treatment of post hip arthroplasty dislocation; without anesthesia
27266	02	583.86	Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia
27275	02	186.48	Manipulation, hip joint, requiring general anesthesia
27280		1,010.04	Arthrodesis, sacroiliac joint (including obtaining graft)
27282		814.89	Arthrodesis, symphysis pubis (including obtaining graft)
27284		1,593.40	Arthrodesis, hip joint (including obtaining graft);
27286		1,635.01	Arthrodesis, hip joint (including obtaining graft); with subtrochanteric osteotomy
27290		1,580.11	Interpelviabdominal amputation (hindquarter amputation)
27295		1,273.48	Disarticulation of hip
27299		I.C.	Unlisted procedure, pelvis or hip joint
27301	03	582.56	Incision and drainage, deep abscess, bursa, or hematoma, thigh or knee region
27303		658.14	Incision, deep, with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess)
27305	02	476.70	Fasciotomy, iliotibial (tenotomy), open
27306	03	398.67	Tenotomy, percutaneous, adductor or hamstring; single tendon (separate procedure)
27307	03	479.22	Tenotomy, percutaneous, adductor or hamstring; multiple tendons
27310	04	713.81	Arthrotomy, knee, with exploration, drainage, or removal of foreign body (eg, infection)
27315	02	494.55	Neurectomy, hamstring muscle
27320	02	481.21	Neurectomy, popliteal (gastrocnemius)
27323	01	184.59	Biopsy, soft tissue of thigh or knee area; superficial
27324	01	389.06	Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular)
27327	02	411.28	Excision, tumor, thigh or knee area; subcutaneous
27328	03	426.30	Excision, tumor, thigh or knee area; deep, subfascial, or intramuscular
27329	04	994.22	Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area
27330	04	405.36	Arthrotomy, knee; with synovial biopsy only
27331	04	483.01	Arthrotomy, knee; including joint exploration, biopsy, or removal of loose or foreign bodies
27332	04	651.62	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral
27333	04	590.31	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral
27334	04	682.58	Arthrotomy, with synovectomy, knee; anterior OR posterior
27335	04	772.52	Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area
27340	03	369.20	Excision, prepatellar bursa
27345	04	488.74	Excision of synovial cyst of popliteal space (eg, Baker's cyst)
27347	04	473.65	Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee
27350	04	652.48	Patellectomy or hemipatellectomy
27355	03	613.86	Excision or curettage of bone cyst or benign tumor of femur;
27356	04	736.07	Excision or curettage of bone cyst or benign tumor of femur; with allograft
27357	05	816.75	Excision or curettage of bone cyst or benign tumor of femur; with autograft (includes obtaining graft)
27358	05	309.73	Excision or curettage of bone cyst or benign tumor of femur; with internal fixation (List in addition to code for primary procedure)
27360	05	865.91	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)

Code	Group	Fee	40.06(8) – Surgical Services Description
27365		1,186.59	Radical resection of tumor, bone, femur or knee
27370		544.57	Injection procedure for knee arthrography
27372	07	466.23	Removal of foreign body, deep, thigh region or knee area
27380	01	611.53	Suture of infrapatellar tendon; primary
27381	03	822.84	Suture of infrapatellar tendon; secondary reconstruction, including fascial or tendon graft
27385	03	651.48	Suture of quadriceps or hamstring muscle rupture; primary
27386	03	850.22	Suture of quadriceps or hamstring muscle rupture; secondary reconstruction, including fascial or tendon graft
27390	01	447.24	Tenotomy, open, hamstring, knee to hip; single tendon
27391	02	586.30	Tenotomy, open, hamstring, knee to hip; multiple tendons, one leg
27392	03	716.36	Tenotomy, open, hamstring, knee to hip; multiple tendons, bilateral
27393	02	519.88	Lengthening of hamstring tendon; single tendon
27394	03	669.32	Lengthening of hamstring tendon; multiple tendons, one leg
27395	03	896.06	Lengthening of hamstring tendon; multiple tendons, bilateral
27396	03	634.23	Transplant, hamstring tendon to patella; single tendon
27397	03	862.54	Transplant, hamstring tendon to patella; multiple tendons
27400	03	691.76	Transfer, tendon or muscle, hamstrings to femur (eg, Egger's type procedure)
27403	04	656.71	Arthrotomy with meniscus repair, knee
27405	04	684.06	Repair, primary, torn ligament and/or capsule, knee; collateral
27407	04	786.56	Repair, primary, torn ligament and/or capsule, knee; cruciate
27409	04	966.72	Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments
27418	03	836.04	Anterior tibial tubercleplasty (eg, Maquet type procedure)
27420	03	759.43	Reconstruction of dislocating patella; (eg, Hauser type procedure)
27422	07	758.09	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure)
27424	03	758.25	Reconstruction of dislocating patella; with patellectomy
27425	07	454.28	Lateral retinacular release, open
27427	03	725.64	Ligamentous reconstruction (augmentation), knee; extra-articular
27428	04	1,065.56	Ligamentous reconstruction (augmentation), knee; intra-articular (open)
27429	04	1,183.55	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular
27430	04	748.70	Quadricepsplasty (eg, Bennett or Thompson type)
27435	04	757.88	Capsulotomy, posterior capsular release, knee
27437	04	660.94	Arthroplasty, patella; without prosthesis
27438	05	834.46	Arthroplasty, patella; with prosthesis
27440		695.50	Arthroplasty, knee, tibial plateau;
27441	05	741.57	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy
27442	05	879.44	Arthroplasty, femoral condyles or tibial plateau(s), knee;
27443	05	828.39	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy
27445		1,271.08	Arthroplasty, knee, hinge prosthesis (eg, Walldius type)
27446		1,146.95	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
27447		1,526.98	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
27448		835.53	Osteotomy, femur, shaft or supracondylar; without fixation

Code	Group	Fee	40.06(8) – Surgical Services Description
27450		1,043.61	Osteotomy, femur, shaft or supracondylar; with fixation
27454		1,277.04	Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft (eg, Sofield type procedure)
27455		963.22	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee)); before epiphyseal closure
27457		992.26	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee)); after epiphyseal closure
27465		1,025.33	Osteoplasty, femur; shortening (excluding 64876)
27466		1,184.99	Osteoplasty, femur; lengthening
27468		1,335.90	Osteoplasty, femur; combined, lengthening and shortening with femoral segment transfer
27470		1,184.89	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)
27472		1,293.25	Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft)
27475		670.57	Arrest, epiphyseal, any method (eg, epiphysiodesis); distal femur
27477		744.30	Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal
27479		962.94	Arrest, epiphyseal, any method (eg, epiphysiodesis); combined distal femur, proximal tibia and fibula
27485		689.05	Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, genu varus or valgus)
27486		1,385.63	Revision of total knee arthroplasty, with or without allograft; one component
27487		1,771.21	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component
27488		1,159.32	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee
27495		1,148.01	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femur
27496	05	499.04	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor);
27497	03	538.88	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor); with debridement of nonviable muscle and/or nerve
27498	03	593.57	Decompression fasciotomy, thigh and/or knee, multiple compartments;
27499	03	676.25	Decompression fasciotomy, thigh and/or knee, multiple compartments; with debridement of nonviable muscle and/or nerve
27500	01	547.15	Closed treatment of femoral shaft fracture, without manipulation
27501	02	571.96	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, without manipulation
27502	02	793.64	Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction
27503	03	800.38	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, with manipulation, with or without skin or skeletal traction
27506		1,276.53	Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws
27507		1,013.76	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage
27508	01	542.07	Closed treatment of femoral fracture, distal end, medial or lateral condyle, without manipulation
27509	03	662.37	Percutaneous skeletal fixation of femoral fracture, distal end, medial or lateral condyle, or supracondylar or transcondylar, with or without intercondylar extension, or distal femoral epiphyseal separation
27510	01	691.74	Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation

Code	Group	Fee	40.06(8) – Surgical Services Description
27511		1,054.28	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, with or without internal or external fixation
27513		1,348.48	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, with or without internal or external fixation
27514		1,298.74	Open treatment of femoral fracture, distal end, medial or lateral condyle, with or without internal or external fixation
27516	01	535.27	Closed treatment of distal femoral epiphyseal separation; without manipulation
27517	01	749.55	Closed treatment of distal femoral epiphyseal separation; with manipulation, with or without skin or skeletal traction
27519		1,130.62	Open treatment of distal femoral epiphyseal separation, with or without internal or external fixation
27520	01	341.69	Closed treatment of patellar fracture, without manipulation
27524		770.53	Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair
27530	01	408.62	Closed treatment of tibial fracture, proximal (plateau); without manipulation
27532	01	641.43	Closed treatment of tibial fracture, proximal (plateau); with or without manipulation, with skeletal traction
27535		916.42	Open treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation
27536		1,152.50	Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal fixation
27538	01	505.59	Closed treatment of intercondylar spine(s) and/or tuberosity fracture(s) of knee, with or without manipulation
27540		957.09	Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without internal or external fixation
27550	01	518.37	Closed treatment of knee dislocation; without anesthesia
27552	01	626.59	Closed treatment of knee dislocation; requiring anesthesia
27556		1,106.73	Open treatment of knee dislocation, with or without internal or external fixation; without primary ligamentous repair or augmentation/reconstruction
27557		1,270.09	Open treatment of knee dislocation, with or without internal or external fixation; with primary ligamentous repair
27558		1,309.32	Open treatment of knee dislocation, with or without internal or external fixation; with primary ligamentous repair, with augmentation/reconstruction
27560	01	393.29	Closed treatment of patellar dislocation; without anesthesia
27562	01	444.77	Closed treatment of patellar dislocation; requiring anesthesia
27566	02	913.46	Open treatment of patellar dislocation, with or without partial or total patellectomy
27570	01	150.61	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)
27580		1,448.84	Arthrodesis, knee, any technique
27590		801.07	Amputation, thigh, through femur, any level;
27591		910.39	Amputation, thigh, through femur, any level; immediate fitting technique including first cast
27592		697.18	Amputation, thigh, through femur, any level; open, circular (guillotine)
27594	03	520.00	Amputation, thigh, through femur, any level; secondary closure or scar revision
27596		748.30	Amputation, thigh, through femur, any level; re-amputation
27598		749.88	Disarticulation at knee
27599		I.C.	Unlisted procedure, femur or knee
27600	03	437.51	Decompression fasciotomy, leg; anterior and/or lateral compartments only

Code	Group	Fee	40.06(8) – Surgical Services Description
27601	03	449.65	Decompression fasciotomy, leg; posterior compartment(s) only
27602	03	532.36	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s)
27603	02	654.82	Incision and drainage, leg or ankle; deep abscess or hematoma
27604	02	549.36	Incision and drainage, leg or ankle; infected bursa
27605	01	492.98	Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia
27606	01	599.24	Tenotomy, percutaneous, Achilles tendon (separate procedure); general anesthesia
27607	02	616.53	Incision (eg, osteomyelitis or bone abscess), leg or ankle
27610	02	653.41	Arthrotomy, ankle, including exploration, drainage, or removal of foreign body
27612	03	570.60	Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening
27613		246.45	Biopsy, soft tissue of leg or ankle area; superficial
27614	02	605.66	Biopsy, soft tissue of leg or ankle area; deep (subfascial or intramuscular)
27615	03	968.41	Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area
27618	02	594.66	Excision, tumor, leg or ankle area; subcutaneous tissue
27619	03	800.65	Excision, tumor, leg or ankle area; deep (subfascial or intramuscular)
27620	04	486.96	Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body
27625	04	630.28	Arthrotomy, with synovectomy, ankle;
27626	04	675.08	Arthrotomy, with synovectomy, ankle; including tenosynovectomy
27630	03	581.19	Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion), leg and/or ankle
27635	03	619.72	Excision or curettage of bone cyst or benign tumor, tibia or fibula;
27637	03	772.83	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with autograft (includes obtaining graft)
27638	03	804.59	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with allograft
27640	02	939.47	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis or exostosis); tibia
27641	02	764.36	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis or exostosis); fibula
27645		1,125.44	Radical resection of tumor, bone; tibia
27646		1,010.76	Radical resection of tumor, bone; fibula
27647	03	851.10	Radical resection of tumor, bone; talus or calcaneus
27648		436.36	Injection procedure for ankle arthrography
27650	03	730.49	Repair, primary, open or percutaneous, ruptured Achilles tendon;
27652	03	778.92	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)
27654	03	732.85	Repair, secondary, Achilles tendon, with or without graft
27656	02	607.94	Repair, fascial defect of leg
27658	01	598.98	Repair, flexor tendon, leg; primary, without graft, each tendon
27659	02	767.55	Repair, flexor tendon, leg; secondary, with or without graft, each tendon
27664	02	670.15	Repair, extensor tendon, leg; primary, without graft, each tendon
27665	02	696.05	Repair, extensor tendon, leg; secondary, with or without graft, each tendon
27675	02	551.04	Repair, dislocating peroneal tendons; without fibular osteotomy
27676	03	644.20	Repair, dislocating peroneal tendons; with fibular osteotomy
27680	03	463.64	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon
27681	02	541.33	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision(s))
27685	03	619.59	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)

Code	Group	Fee	40.06(8) – Surgical Services Description
27686	03	848.90	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each
27687	03	495.19	Gastrocnemius recession (eg, Strayer procedure)
27690	04	644.05	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)
27691	04	755.11	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)
27692	03	119.02	Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon (List separately in addition to code for primary procedure)
27695	02	527.35	Repair, primary, disrupted ligament, ankle; collateral
27696	02	627.47	Repair, primary, disrupted ligament, ankle; both collateral ligaments
27698	02	694.20	Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)
27700	05	631.83	Arthroplasty, ankle;
27702		1,019.34	Arthroplasty, ankle; with implant (total ankle)
27703		1,146.15	Arthroplasty, ankle; revision, total ankle
27704	02	541.86	Removal of ankle implant
27705	02	789.78	Osteotomy; tibia
27707	02	397.20	Osteotomy; fibula
27709	02	769.19	Osteotomy; tibia and fibula
27712		1,060.77	Osteotomy; multiple, with realignment on intramedullary rod (eg, Sofield type procedure)
27715		1,071.11	Osteoplasty, tibia and fibula, lengthening or shortening
27720		902.17	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)
27722		892.89	Repair of nonunion or malunion, tibia; with sliding graft
27724		1,285.88	Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)
27725		1,167.40	Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method
27727		1,032.96	Repair of congenital pseudarthrosis, tibia
27730	02	1,053.85	Arrest, epiphyseal (epiphysiodesis), open; distal tibia
27732	02	712.02	Arrest, epiphyseal (epiphysiodesis), open; distal fibula
27734	02	620.92	Arrest, epiphyseal (epiphysiodesis), open; distal tibia and fibula
27740	02	1,266.50	Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula;
27742	02	970.66	Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula; and distal femur
27745	03	774.85	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, tibia
27750	01	362.25	Closed treatment of tibial shaft fracture (with or without fibular fracture); without manipulation
27752	01	560.63	Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction
27756	03	564.03	Percutaneous skeletal fixation of tibial shaft fracture (with or without fibular fracture) (eg, pins or screws)
27758	04	881.59	Open treatment of tibial shaft fracture, (with or without fibular fracture) with plate/screws, with or without cerclage
27759	04	1,023.03	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage
27760	01	348.91	Closed treatment of medial malleolus fracture; without manipulation
27762	01	523.52	Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal

Code	Group	Fee	40.06(8) – Surgical Services Description
			traction
27766	03	658.98	Open treatment of medial malleolus fracture, with or without internal or external fixation
27780	01	319.32	Closed treatment of proximal fibula or shaft fracture; without manipulation
27781	01	453.92	Closed treatment of proximal fibula or shaft fracture; with manipulation
27784	03	575.02	Open treatment of proximal fibula or shaft fracture, with or without internal or external fixation
27786	01	335.15	Closed treatment of distal fibular fracture (lateral malleolus); without manipulation
27788	01	461.94	Closed treatment of distal fibular fracture (lateral malleolus); with manipulation
27792	03	618.03	Open treatment of distal fibular fracture (lateral malleolus), with or without internal or external fixation
27808	01	359.95	Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation
27810	01	511.83	Closed treatment of bimalleolar ankle fracture, (including Potts); with manipulation
27814	03	816.68	Open treatment of bimalleolar ankle fracture, with or without internal or external fixation
27816	01	332.82	Closed treatment of trimalleolar ankle fracture; without manipulation
27818	01	531.32	Closed treatment of trimalleolar ankle fracture; with manipulation
27822	03	908.93	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip
27823	03	1,033.50	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip
27824	01	357.45	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; without manipulation
27825	02	609.17	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation
27826	03	738.75	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of fibula only
27827	03	1,135.99	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of tibia only
27828	04	1,277.27	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of both tibia and fibula
27829	02	519.92	Open treatment of distal tibiofibular joint (syndesmosis) disruption, with or without internal or external fixation
27830	01	374.27	Closed treatment of proximal tibiofibular joint dislocation; without anesthesia
27831	01	380.51	Closed treatment of proximal tibiofibular joint dislocation; requiring anesthesia
27832	02	537.01	Open treatment of proximal tibiofibular joint dislocation, with or without internal or external fixation, or with excision of proximal fibula
27840	01	353.41	Closed treatment of ankle dislocation; without anesthesia
27842	01	475.53	Closed treatment of ankle dislocation; requiring anesthesia, with or without percutaneous skeletal fixation
27846	03	751.42	Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; without repair or internal fixation
27848	03	886.99	Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; with repair or internal or external fixation
27860	01	184.07	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)
27870	04	1,036.88	Arthrodesis, ankle, open
27871	04	713.42	Arthrodesis, tibiofibular joint, proximal or distal
27880		810.36	Amputation, leg, through tibia and fibula;

Code	Group	Fee	40.06(8) – Surgical Services Description
27881		901.97	Amputation, leg, through tibia and fibula; with immediate fitting technique including application of first cast
27882		666.06	Amputation, leg, through tibia and fibula; open, circular (guillotine)
27884	03	600.85	Amputation, leg, through tibia and fibula; secondary closure or scar revision
27886		679.35	Amputation, leg, through tibia and fibula; re-amputation
27888		730.23	Amputation, ankle, through malleoli of tibia and fibula (eg, Syme, Pirogoff type procedures), with plastic closure and resection of nerves
27889	03	703.27	Ankle disarticulation
27892	03	556.09	Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve
27893	03	551.44	Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve
27894	03	774.39	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve
27899		I.C.	Unlisted procedure, leg or ankle
28001		359.38	Incision and drainage, bursa, foot
28002	03	498.59	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space
28003	03	677.69	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas
28005	03	636.13	Incision, bone cortex (eg, osteomyelitis or bone abscess), foot
28008	03	427.26	Fasciotomy, foot and/or toe
28010		354.30	Tenotomy, percutaneous, toe; single tendon
28011	03	489.51	Tenotomy, percutaneous, toe; multiple tendons
28020	02	509.67	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; intertarsal or tarsometatarsal joint
28022	02	454.94	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; metatarsophalangeal joint
28024	02	444.14	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; interphalangeal joint
28030	04	413.34	Neurectomy, intrinsic musculature of foot
28035	04	450.89	Release, tarsal tunnel (posterior tibial nerve decompression)
28043	02	393.38	Excision, tumor, foot; subcutaneous tissue
28045	03	458.09	Excision, tumor, foot; deep, subfascial, intramuscular
28046	03	821.01	Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot
28050	02	423.33	Arthrotomy with biopsy; intertarsal or tarsometatarsal joint
28052	02	418.45	Arthrotomy with biopsy; metatarsophalangeal joint
28054	02	391.25	Arthrotomy with biopsy; interphalangeal joint
28060	02	491.10	Fasciectomy, plantar fascia; partial (separate procedure)
28062	03	576.94	Fasciectomy, plantar fascia; radical (separate procedure)
28070	03	467.77	Synovectomy; intertarsal or tarsometatarsal joint, each
28072	03	466.47	Synovectomy; metatarsophalangeal joint, each
28080	03	402.59	Excision, interdigital (Morton) neuroma, single, each
28086	02	604.33	Synovectomy, tendon sheath, foot; flexor
28088	02	460.84	Synovectomy, tendon sheath, foot; extensor
28090	03	440.38	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (eg, cyst or ganglion);

Code	Group	Fee	40.06(8) – Surgical Services Description
			foot
28092	03	420.21	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (eg, cyst or ganglion); toe(s), each
28100	02	628.89	Excision or curettage of bone cyst or benign tumor, talus or calcaneus;
28102	03	581.24	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with iliac or other autograft (includes obtaining graft)
28103	03	631.34	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograft
28104	02	485.26	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus;
28106	03	499.70	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with iliac or other autograft (includes obtaining graft)
28107	03	541.17	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with allograft
28108		404.71	Excision or curettage of bone cyst or benign tumor, phalanges of foot
28110	03	425.36	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
28111	03	514.01	Ostectomy, complete excision; first metatarsal head
28112	03	472.54	Ostectomy, complete excision; other metatarsal head (second, third or fourth)
28113	03	490.11	Ostectomy, complete excision; fifth metatarsal head
28114	03	920.88	Ostectomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (eg, Clayton type procedure)
28116	03	632.57	Ostectomy, excision of tarsal coalition
28118	04	553.42	Ostectomy, calcaneus;
28119	04	491.34	Ostectomy, calcaneus; for spur, with or without plantar fascial release
28120	07	593.62	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus
28122	03	641.91	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus
28124		460.69	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe
28126	03	375.16	Resection, partial or complete, phalangeal base, each toe
28130	03	628.06	Talectomy (astragalectomy)
28140	03	638.68	Metatarsectomy
28150	03	424.83	Phalangectomy, toe, each toe
28153	03	382.96	Resection, condyle(s), distal end of phalanx, each toe
28160	03	398.68	Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each
28171	03	642.28	Radical resection of tumor, bone; tarsal (except talus or calcaneus)
28173	03	717.15	Radical resection of tumor, bone; metatarsal
28175	03	536.35	Radical resection of tumor, bone; phalanx of toe
28190		354.03	Removal of foreign body, foot; subcutaneous
28192	02	464.54	Removal of foreign body, foot; deep
28193	04	506.17	Removal of foreign body, foot; complicated
28200	03	444.77	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon
28202	03	632.72	Repair, tendon, flexor, foot; secondary with free graft, each tendon (includes obtaining graft)
28208	03	426.83	Repair, tendon, extensor, foot; primary or secondary, each tendon
28210	03	567.11	Repair, tendon, extensor, foot; secondary with free graft, each tendon (includes obtaining graft)
28220		427.61	Tenolysis, flexor, foot; single tendon

Code	Group	Fee	40.06(8) – Surgical Services Description
28222	01	490.26	Tenolysis, flexor, foot; multiple tendons
28225	01	377.36	Tenolysis, extensor, foot; single tendon
28226	01	429.42	Tenolysis, extensor, foot; multiple tendons
28230		417.71	Tenotomy, open, tendon flexor; foot, single or multiple tendon(s) (separate procedure)
28232		383.44	Tenotomy, open, tendon flexor; toe, single tendon (separate procedure)
28234	02	388.11	Tenotomy, open, extensor, foot or toe, each tendon
28238	03	666.07	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)
28240	02	421.87	Tenotomy, lengthening, or release, abductor hallucis muscle
28250	03	527.52	Division of plantar fascia and muscle (eg, Steindler stripping) (separate procedure)
28260	03	637.65	Capsulotomy, midfoot; medial release only (separate procedure)
28261	03	877.15	Capsulotomy, midfoot; with tendon lengthening
28262	04	1,280.20	Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)
28264	01	801.05	Capsulotomy, midtarsal (eg, Heyman type procedure)
28270	03	452.12	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)
28272		378.48	Capsulotomy; interphalangeal joint, each joint (separate procedure)
28280	02	527.04	Syndactylization, toes (eg, webbing or Kelikian type procedure)
28285	03	447.04	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)
28286	04	436.63	Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)
28288	03	483.77	Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head
28289	03	678.01	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint
28290	02	537.47	Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (eg, Silver type procedure)
28292	02	629.29	Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure
28293	03	847.80	Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant
28294	03	686.46	Correction, hallux valgus (bunion), with or without sesamoidectomy; with tendon transplants (eg, Joplin type procedure)
28296	03	735.11	Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)
28297	03	777.20	Correction, hallux valgus (bunion), with or without sesamoidectomy; Lapidus type procedure
28298	03	647.67	Correction, hallux valgus (bunion), with or without sesamoidectomy; by phalanx osteotomy
28299	05	810.36	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy
28300	02	958.97	Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation
28302	02	954.07	Osteotomy; talus
28304	02	725.31	Osteotomy, tarsal bones, other than calcaneus or talus;
28305	03	874.47	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)
28306	04	553.08	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal
28307	04	752.68	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)
28308	02	481.67	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first

Code	Group	Fee	40.06(8) – Surgical Services Description
			metatarsal, each
28309	04	879.89	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)
28310	03	495.02	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
28312	03	445.77	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe
28313	02	484.19	Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)
28315	04	452.22	Sesamoidectomy, first toe (separate procedure)
28320	04	676.64	Repair, nonunion or malunion; tarsal bones
28322	04	783.42	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)
28340	04	595.83	Reconstruction, toe, macrodactyly; soft tissue resection
28341	04	664.12	Reconstruction, toe, macrodactyly; requiring bone resection
28344	04	467.66	Reconstruction, toe(s); polydactyly
28345	04	547.81	Reconstruction, toe(s); syndactyly, with or without skin graft(s), each web
28360		1,012.98	Reconstruction, cleft foot
28400	01	272.37	Closed treatment of calcaneal fracture; without manipulation
28405	02	427.02	Closed treatment of calcaneal fracture; with manipulation
28406	02	555.71	Percutaneous skeletal fixation of calcaneal fracture, with manipulation
28415	03	1,240.56	Open treatment of calcaneal fracture, with or without internal or external fixation;
28420	04	1,256.24	Open treatment of calcaneal fracture, with or without internal or external fixation; with primary iliac or other autogenous bone graft (includes obtaining graft)
28430		260.28	Closed treatment of talus fracture; without manipulation
28435	02	334.20	Closed treatment of talus fracture; with manipulation
28436	02	449.93	Percutaneous skeletal fixation of talus fracture, with manipulation
28445	03	1,099.60	Open treatment of talus fracture, with or without internal or external fixation
28450		252.21	Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each
28455		299.47	Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each
28456	02	291.43	Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each
28465	03	563.98	Open treatment of tarsal bone fracture (except talus and calcaneus), with or without internal or external fixation, each
28470		247.47	Closed treatment of metatarsal fracture; without manipulation, each
28475		297.42	Closed treatment of metatarsal fracture; with manipulation, each
28476	02	353.92	Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each
28485	04	477.69	Open treatment of metatarsal fracture, with or without internal or external fixation, each
28490		139.06	Closed treatment of fracture great toe, phalanx or phalanges; without manipulation
28495		171.86	Closed treatment of fracture great toe, phalanx or phalanges; with manipulation
28496	02	509.30	Percutaneous skeletal fixation of fracture great toe, phalanx or phalanges, with manipulation
28505	03	570.60	Open treatment of fracture great toe, phalanx or phalanges, with or without internal or external fixation
28510		129.37	Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each
28515		159.57	Closed treatment of fracture, phalanx or phalanges, other than great toe; with manipulation, each
28525	03	533.12	Open treatment of fracture, phalanx or phalanges, other than great toe, with or without internal or

Code	Group	Fee	40.06(8) – Surgical Services Description
			external fixation, each
28530		132.45	Closed treatment of sesamoid fracture
28531	03	479.16	Open treatment of sesamoid fracture, with or without internal fixation
28540		206.61	Closed treatment of tarsal bone dislocation, other than talotarsal; without anesthesia
28545	01	224.94	Closed treatment of tarsal bone dislocation, other than talotarsal; requiring anesthesia
28546	02	469.76	Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation
28555	02	753.33	Open treatment of tarsal bone dislocation, with or without internal or external fixation
28570		192.52	Closed treatment of talotarsal joint dislocation; without anesthesia
28575	01	325.23	Closed treatment of talotarsal joint dislocation; requiring anesthesia
28576	03	605.13	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation
28585	03	684.84	Open treatment of talotarsal joint dislocation, with or without internal or external fixation
28600		218.65	Closed treatment of tarsometatarsal joint dislocation; without anesthesia
28605	01	272.44	Closed treatment of tarsometatarsal joint dislocation; requiring anesthesia
28606	02	884.30	Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation
28615	03	668.30	Open treatment of tarsometatarsal joint dislocation, with or without internal or external fixation
28630		121.83	Closed treatment of metatarsophalangeal joint dislocation; without anesthesia
28635	01	150.70	Closed treatment of metatarsophalangeal joint dislocation; requiring anesthesia
28636	03	377.38	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation
28645	03	418.34	Open treatment of metatarsophalangeal joint dislocation, with or without internal or external fixation
28660		118.15	Closed treatment of interphalangeal joint dislocation; without anesthesia
28665	01	150.65	Closed treatment of interphalangeal joint dislocation; requiring anesthesia
28666	03	364.08	Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation
28675	03	496.18	Open treatment of interphalangeal joint dislocation, with or without internal or external fixation
28705	04	1,308.86	Arthrodesis; pantalar
28715	04	970.40	Arthrodesis; triple
28725	04	846.01	Arthrodesis; subtalar
28730	04	816.62	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;
28735	04	794.30	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)
28737	05	701.92	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)
28740	04	831.40	Arthrodesis, midtarsal or tarsometatarsal, single joint
28750	04	858.83	Arthrodesis, great toe; metatarsophalangeal joint
28755	04	490.27	Arthrodesis, great toe; interphalangeal joint
28760	04	669.48	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)
28800		599.22	Amputation, foot; midtarsal (eg, Chopart type procedure)
28805		599.80	Amputation, foot; transmetatarsal
28810	02	459.64	Amputation, metatarsal, with toe, single
28820	02	542.82	Amputation, toe; metatarsophalangeal joint
28825	02	484.03	Amputation, toe; interphalangeal joint
28899		I.C.	Unlisted procedure, foot or toes
29000		225.90	Application of halo type body cast (see 20661-20663 for insertion)

Code	Group	Fee	40.06(8) – Surgical Services Description
29010		226.69	Application of Risser jacket, localizer, body; only
29015		225.26	Application of Risser jacket, localizer, body; including head
29020		224.37	Application of turnbuckle jacket, body; only
29025		235.54	Application of turnbuckle jacket, body; including head
29035		220.87	Application of body cast, shoulder to hips;
29040		204.65	Application of body cast, shoulder to hips; including head, Minerva type
29044		250.63	Application of body cast, shoulder to hips; including one thigh
29046		241.02	Application of body cast, shoulder to hips; including both thighs
29049		90.03	Application, cast; figure-of-eight
29055		194.27	Application, cast; shoulder spica
29058		117.73	Application, cast; plaster Velpeau
29065		90.12	Application, cast; shoulder to hand (long arm)
29075		83.52	Application, cast; elbow to finger (short arm)
29085		88.56	Application, cast; hand and lower forearm (gauntlet)
29086		64.68	Application, cast; finger (eg, contracture)
29105		86.45	Application of long arm splint (shoulder to hand)
29125		66.08	Application of short arm splint (forearm to hand); static
29126		81.30	Application of short arm splint (forearm to hand); dynamic
29130		39.62	Application of finger splint; static
29131		52.71	Application of finger splint; dynamic
29200		57.63	Strapping; thorax
29220		56.88	Strapping; low back
29240		64.83	Strapping; shoulder (eg, Velpeau)
29260		53.86	Strapping; elbow or wrist
29280		54.88	Strapping; hand or finger
29305		221.52	Application of hip spica cast; one leg
29325		240.64	Application of hip spica cast; one and one-half spica or both legs
29345		130.93	Application of long leg cast (thigh to toes);
29355		134.45	Application of long leg cast (thigh to toes); walker or ambulatory type
29358		143.44	Application of long leg cast brace
29365		117.40	Application of cylinder cast (thigh to ankle)
29405		85.95	Application of short leg cast (below knee to toes);
29425		92.93	Application of short leg cast (below knee to toes); walking or ambulatory type
29435		113.60	Application of patellar tendon bearing (PTB) cast
29440		52.14	Adding walker to previously applied cast
29445		149.59	Application of rigid total contact leg cast
29450		144.36	Application of clubfoot cast with molding or manipulation, long or short leg
29505		76.60	Application of long leg splint (thigh to ankle or toes)

Code	Group	Fee	40.06(8) – Surgical Services Description
29515		65.76	Application of short leg splint (calf to foot)
29520		57.64	Strapping; hip
29530		56.72	Strapping; knee
29540		38.01	Strapping; ankle and/or foot
29550		36.81	Strapping; toes
29580		50.69	Strapping; Unna boot
29590		51.84	Denis-Browne splint strapping
29700		60.99	Removal or bivalving; gauntlet, boot or body cast
29705		65.56	Removal or bivalving; full arm or full leg cast
29710		119.64	Removal or bivalving; shoulder or hip spica, Minerva, or Risser jacket, etc.
29715		86.50	Removal or bivalving; turnbuckle jacket
29720		75.61	Repair of spica, body cast or jacket
29730		64.76	Windowing of cast
29740		94.85	Wedging of cast (except clubfoot casts)
29750		97.05	Wedging of clubfoot cast
29799		I.C.	Unlisted procedure, casting or strapping
29800	03	572.52	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)
29804	03	685.09	Arthroscopy, temporomandibular joint, surgical
29805	03	490.19	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
29806	03	1,074.57	Arthroscopy, shoulder, surgical; capsulorrhaphy
29807	03	1,048.00	Arthroscopy, shoulder, surgical; repair of SLAP lesion
29819	03	606.40	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
29820	03	559.90	Arthroscopy, shoulder, surgical; synovectomy, partial
29821	03	611.31	Arthroscopy, shoulder, surgical; synovectomy, complete
29822	03	593.82	Arthroscopy, shoulder, surgical; debridement, limited
29823	03	648.27	Arthroscopy, shoulder, surgical; debridement, extensive
29824	05	661.40	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
29825	03	605.26	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
29826	03	696.58	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release
29827	05	1,122.83	Arthroscopy, shoulder, surgical; with rotator cuff repair
29830	03	466.63	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
29834	03	508.75	Arthroscopy, elbow, surgical; with removal of loose body or foreign body
29835	03	519.00	Arthroscopy, elbow, surgical; synovectomy, partial
29836	03	603.46	Arthroscopy, elbow, surgical; synovectomy, complete
29837	03	547.24	Arthroscopy, elbow, surgical; debridement, limited
29838	03	614.01	Arthroscopy, elbow, surgical; debridement, extensive
29840	03	454.31	Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)
29843	03	489.48	Arthroscopy, wrist, surgical; for infection, lavage and drainage
29844	03	511.72	Arthroscopy, wrist, surgical; synovectomy, partial

Code	Group	Fee	40.06(8) – Surgical Services Description
29845	03	582.43	Arthroscopy, wrist, surgical; synovectomy, complete
29846	03	537.07	Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement
29847	03	556.73	Arthroscopy, wrist, surgical; internal fixation for fracture or instability
29848	09	462.28	Endoscopy, wrist, surgical, with release of transverse carpal ligament
29850	04	547.61	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)
29851	04	965.82	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy)
29855	04	816.53	Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation (includes arthroscopy)
29856	04	1,047.77	Arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal or external fixation (includes arthroscopy)
29860	04	631.76	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)
29861	04	695.80	Arthroscopy, hip, surgical; with removal of loose body or foreign body
29862	09	777.00	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
29863	04	775.19	Arthroscopy, hip, surgical; with synovectomy
29870	03	417.44	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29871	03	521.22	Arthroscopy, knee, surgical; for infection, lavage and drainage
29873		520.79	Arthroscopy, knee, surgical; with lateral release
29874	03	548.62	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)
29875	04	511.32	Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)
29876	04	628.49	Arthroscopy, knee, surgical; synovectomy, major, two or more compartments (eg, medial or lateral)
29877	04	591.77	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)
29879	03	637.41	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
29880	04	667.27	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving)
29881	04	619.02	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)
29882	03	664.39	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)
29883	03	839.09	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)
29884	03	589.33	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)
29885	03	717.51	Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)
29886	03	604.77	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion
29887	03	714.36	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation
29888	03	1,019.22	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29889	03	1,194.31	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction
29891	03	668.50	Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and/or tibia, including drilling of the defect
29892	03	704.54	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)
29893	09	481.98	Endoscopic plantar fasciotomy

Code	Group	Fee	40.06(8) – Surgical Services Description
29894	03	535.31	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body
29895	03	525.51	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial
29897	03	550.61	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited
29898	03	612.01	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive
29899	03	1,009.05	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis
29900	03	470.85	Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy
29901	03	518.39	Arthroscopy, metacarpophalangeal joint, surgical; with debridement
29902	03	554.39	Arthroscopy, metacarpophalangeal joint, surgical; with reduction of displaced ulnar collateral ligament (eg, Stenar lesion)
29999		I.C.	Unlisted procedure, arthroscopy
30000		234.15	Drainage abscess or hematoma, nasal, internal approach
30020		198.14	Drainage abscess or hematoma, nasal septum
30100		123.96	Biopsy, intranasal
30110		207.30	Excision, nasal polyp(s), simple
30115	02	344.22	Excision, nasal polyp(s), extensive
30117	03	311.90	Excision or destruction (eg, laser), intranasal lesion; internal approach
30118	03	695.48	Excision or destruction (eg, laser), intranasal lesion; external approach (lateral rhinotomy)
30120	01	446.16	Excision or surgical planing of skin of nose for rhinophyma
30124		251.83	Excision dermoid cyst, nose; simple, skin, subcutaneous
30125	02	538.67	Excision dermoid cyst, nose; complex, under bone or cartilage
30130	03	283.14	Excision turbinate, partial or complete, any method
30140	02	305.02	Submucous resection turbinate, partial or complete, any method
30150	03	694.78	Rhinectomy; partial
30160	04	711.55	Rhinectomy; total
30200		103.17	Injection into turbinate(s), therapeutic
30210		135.20	Displacement therapy (Proetz type)
30220		251.66	Insertion, nasal septal prosthesis (button)
30300		245.64	Removal foreign body, intranasal; office type procedure
30310	01	213.90	Removal foreign body, intranasal; requiring general anesthesia
30320	02	372.24	Removal foreign body, intranasal; by lateral rhinotomy
30400	04	785.23	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	05	988.87	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	05	1,166.62	Rhinoplasty, primary; including major septal repair
30430	03	635.45	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	05	928.39	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	07	1,352.01	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	07	732.80	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	09	1,382.67	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30465	09	796.60	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)

Code	Group	Fee	40.06(8) – Surgical Services Description
30520	04	446.36	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30540	05	547.97	Repair choanal atresia; intranasal
30545	05	821.39	Repair choanal atresia; transpalatine
30560	02	258.21	Lysis intranasal synechia
30580	04	572.14	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)
30600	04	518.24	Repair fistula; oronasal
30620	07	484.60	Septal or other intranasal dermatoplasty (does not include obtaining graft)
30630	07	547.22	Repair nasal septal perforations
30801	01	135.58	Cautery and/or ablation, mucosa of turbinates, unilateral or bilateral, any method, (separate procedure); superficial
30802	01	196.19	Cautery and/or ablation, mucosa of turbinates, unilateral or bilateral, any method, (separate procedure); intramural
30901		106.26	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
30903	01	180.30	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method
30905	01	230.18	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial
30906	01	265.62	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent
30915	02	534.47	Ligation arteries; ethmoidal
30920	03	710.94	Ligation arteries; internal maxillary artery, transantral
30930	04	120.37	Fracture nasal turbinate(s), therapeutic
30999		I.C.	Unlisted procedure, nose
31000		169.03	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)
31002		215.81	Lavage by cannulation; sphenoid sinus
31020	02	291.74	Sinusotomy, maxillary (antrotomy); intranasal
31030	03	475.91	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps
31032	04	500.53	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps
31040		644.95	Pterygomaxillary fossa surgery, any approach
31050	02	402.52	Sinusotomy, sphenoid, with or without biopsy;
31051	04	534.56	Sinusotomy, sphenoid, with or without biopsy; with mucosal stripping or removal of polyp(s)
31070	02	348.86	Sinusotomy frontal; external, simple (trephine operation)
31075	04	672.07	Sinusotomy frontal; transorbital, unilateral (for mucocele or osteoma, Lynch type)
31080	04	813.86	Sinusotomy frontal; obliterative without osteoplastic flap, brow incision (includes ablation)
31081	04	945.39	Sinusotomy frontal; obliterative, without osteoplastic flap, coronal incision (includes ablation)
31084	04	966.72	Sinusotomy frontal; obliterative, with osteoplastic flap, brow incision
31085	04	1,016.14	Sinusotomy frontal; obliterative, with osteoplastic flap, coronal incision
31086	04	932.52	Sinusotomy frontal; nonobliterative, with osteoplastic flap, brow incision
31087	04	947.62	Sinusotomy frontal; nonobliterative, with osteoplastic flap, coronal incision
31090	05	745.09	Sinusotomy, unilateral, three or more paranasal sinuses (frontal, maxillary, ethmoid, sphenoid)
31200	02	407.65	Ethmoidectomy; intranasal, anterior
31201	05	623.74	Ethmoidectomy; intranasal, total
31205	03	728.03	Ethmoidectomy; extranasal, total
31225		1,353.01	Maxillectomy; without orbital exenteration

Code	Group	Fee	40.06(8) – Surgical Services Description
31230		1,520.28	Maxillectomy; with orbital exenteration (en bloc)
31231		194.13	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
31233	02	277.18	Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)
31235	01	321.14	Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)
31237	02	347.50	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)
31238	01	361.07	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage
31239	04	693.23	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy
31240	02	179.21	Nasal/sinus endoscopy, surgical; with concha bullosa resection
31254	03	308.50	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)
31255	05	454.72	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)
31256	03	222.67	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;
31267	03	360.11	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus
31276	03	573.79	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus
31287	03	262.31	Nasal/sinus endoscopy, surgical, with sphenoidotomy;
31288	03	304.17	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus
31290		1,204.65	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region
31291		1,276.52	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; sphenoid region
31292		1,043.00	Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression
31293		1,131.23	Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression
31294		1,303.11	Nasal/sinus endoscopy, surgical; with optic nerve decompression
31299		I.C.	Unlisted procedure, accessory sinuses
31300	05	1,080.92	Laryngotomy (thyrotomy, laryngofissure); with removal of tumor or laryngocele, cordectomy
31320	02	517.57	Laryngotomy (thyrotomy, laryngofissure); diagnostic
31360		1,274.49	Laryngectomy; total, without radical neck dissection
31365		1,714.82	Laryngectomy; total, with radical neck dissection
31367		1,613.79	Laryngectomy; subtotal supraglottic, without radical neck dissection
31368		1,973.97	Laryngectomy; subtotal supraglottic, with radical neck dissection
31370		1,578.42	Partial laryngectomy (hemilaryngectomy); horizontal
31375		1,459.64	Partial laryngectomy (hemilaryngectomy); laterovertical
31380		1,457.05	Partial laryngectomy (hemilaryngectomy); anterovertical
31382		1,522.93	Partial laryngectomy (hemilaryngectomy); antero-latero-vertical
31390		2,002.48	Pharyngolaryngectomy, with radical neck dissection; without reconstruction
31395		2,312.02	Pharyngolaryngectomy, with radical neck dissection; with reconstruction
31400	02	835.67	Arytenoidectomy or arytenoidopexy, external approach
31420	02	823.54	Epiglottidectomy
31500		116.45	Intubation, endotracheal, emergency procedure
31502		88.82	Tracheotomy tube change prior to establishment of fistula tract

Code	Group	Fee	40.06(8) – Surgical Services Description
31505		90.68	Laryngoscopy, indirect; diagnostic (separate procedure)
31510	02	221.97	Laryngoscopy, indirect; with biopsy
31511	02	224.15	Laryngoscopy, indirect; with removal of foreign body
31512	02	224.55	Laryngoscopy, indirect; with removal of lesion
31513	02	147.40	Laryngoscopy, indirect; with vocal cord injection
31515	01	228.47	Laryngoscopy direct, with or without tracheoscopy; for aspiration
31520		170.28	Laryngoscopy direct, with or without tracheoscopy; diagnostic, newborn
31525	01	268.49	Laryngoscopy direct, with or without tracheoscopy; diagnostic, except newborn
31526	02	177.28	Laryngoscopy direct, with or without tracheoscopy; diagnostic, with operating microscope
31527	01	210.90	Laryngoscopy direct, with or without tracheoscopy; with insertion of obturator
31528	02	156.19	Laryngoscopy direct, with or without tracheoscopy; with dilation, initial
31529	02	180.17	Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent
31530	02	219.62	Laryngoscopy, direct, operative, with foreign body removal;
31531	03	241.37	Laryngoscopy, direct, operative, with foreign body removal; with operating microscope
31535	02	212.41	Laryngoscopy, direct, operative, with biopsy;
31536	03	239.40	Laryngoscopy, direct, operative, with biopsy; with operating microscope
31540	03	275.04	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis;
31541	04	300.60	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope
31560	05	352.94	Laryngoscopy, direct, operative, with arytenoidectomy;
31561	05	383.66	Laryngoscopy, direct, operative, with arytenoidectomy; with operating microscope
31570	02	396.22	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic;
31571	02	282.31	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope
31575		123.73	Laryngoscopy, flexible fiberoptic; diagnostic
31576	02	231.68	Laryngoscopy, flexible fiberoptic; with biopsy
31577	02	257.10	Laryngoscopy, flexible fiberoptic; with removal of foreign body
31578	02	293.45	Laryngoscopy, flexible fiberoptic; with removal of lesion
31579		251.11	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy
31580	05	966.34	Laryngoplasty; for laryngeal web, two stage, with keel insertion and removal
31582	05	1,603.36	Laryngoplasty; for laryngeal stenosis, with graft or core mold, including tracheotomy
31584		1,405.38	Laryngoplasty; with open reduction of fracture
31585	01	421.03	Treatment of closed laryngeal fracture; without manipulation
31586	02	675.23	Treatment of closed laryngeal fracture; with closed manipulative reduction
31587		906.83	Laryngoplasty, cricoid split
31588	05	1,079.13	Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy)
31590	05	651.83	Laryngeal reinnervation by neuromuscular pedicle
31595	02	659.09	Section recurrent laryngeal nerve, therapeutic (separate procedure), unilateral
31599		I.C.	Unlisted procedure, larynx
31600	02	417.57	Tracheostomy, planned (separate procedure);
31601	03	283.12	Tracheostomy, planned (separate procedure); under two years
31603		241.22	Tracheostomy, emergency procedure; transtracheal
31605		196.78	Tracheostomy, emergency procedure; cricothyroid membrane

Code	Group	Fee	40.06(8) – Surgical Services Description
31610		668.90	Tracheostomy, fenestration procedure with skin flaps
31611	03	477.52	Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)
31612	01	83.63	Tracheal puncture, percutaneous with transtracheal aspiration and/or injection
31613	02	414.68	Tracheostoma revision; simple, without flap rotation
31614	02	615.93	Tracheostoma revision; complex, with flap rotation
31615	01	194.78	Tracheobronchoscopy through established tracheostomy incision
31622	01	285.71	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)
31623	02	326.58	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with brushing or protected brushings
31624	02	293.82	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial alveolar lavage
31625	02	358.77	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial or endobronchial biopsy(s), single or multiple sites
31628	02	381.51	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe
31629	02	182.93	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)
31630	02	238.78	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with tracheal or bronchial dilation or closed reduction of fracture
31631	02	260.66	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with tracheal dilation and placement of tracheal stent
31632		75.98	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)
31633		93.24	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)
31635	02	216.29	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with removal of foreign body
31640	02	298.47	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with excision of tumor
31641	02	289.47	Bronchoscopy, (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)
31643	02	192.23	Bronchoscopy, (rigid or flexible); with placement of catheter(s) for intracavitary radioelement application
31645	01	174.55	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess)
31646	01	152.30	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, subsequent
31656	01	124.63	Bronchoscopy, (rigid or flexible); with injection of contrast material for segmental bronchography (fiberscope only)
31700	01	139.35	Catheterization, transglottic (separate procedure)
31708		79.72	Instillation of contrast material for laryngography or bronchography, without catheterization
31710		81.05	Catheterization for bronchography, with or without instillation of contrast material
31715		68.83	Transtracheal injection for bronchography
31717	01	208.02	Catheterization with bronchial brush biopsy
31720	01	103.20	Catheter aspiration (separate procedure); nasotracheal
31725		156.34	Catheter aspiration (separate procedure); tracheobronchial with fiberscope, bedside
31730	01	206.45	Transtracheal (percutaneous) introduction of needle wire dilator/stent or indwelling tube for oxygen

Code	Group	Fee	40.06(8) – Surgical Services Description
			therapy
31750	05	1,014.84	Tracheoplasty; cervical
31755	02	1,240.24	Tracheoplasty; tracheopharyngeal fistulization, each stage
31760		1,351.48	Tracheoplasty; intrathoracic
31766		1,839.92	Carinal reconstruction
31770		1,365.76	Bronchoplasty; graft repair
31775		1,492.65	Bronchoplasty; excision stenosis and anastomosis
31780		1,192.76	Excision tracheal stenosis and anastomosis; cervical
31781		1,474.70	Excision tracheal stenosis and anastomosis; cervicothoracic
31785		1,130.29	Excision of tracheal tumor or carcinoma; cervical
31786		1,538.68	Excision of tracheal tumor or carcinoma; thoracic
31800		509.81	Suture of tracheal wound or injury; cervical
31805		854.16	Suture of tracheal wound or injury; intrathoracic
31820	01	414.23	Surgical closure tracheostomy or fistula; without plastic repair
31825	02	595.21	Surgical closure tracheostomy or fistula; with plastic repair
31830	02	421.65	Revision of tracheostomy scar
31899		I.C.	Unlisted procedure, trachea, bronchi
32000	01	192.41	Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent
32002		226.44	Thoracentesis with insertion of tube with or without water seal (eg, for pneumothorax) (separate procedure)
32005		366.26	Chemical pleurodesis (eg, for recurrent or persistent pneumothorax)
32020		223.73	Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)
32035		612.58	Thoracostomy; with rib resection for empyema
32036		681.72	Thoracostomy; with open flap drainage for empyema
32095		579.04	Thoracotomy, limited, for biopsy of lung or pleura
32100		958.60	Thoracotomy, major; with exploration and biopsy
32110		1,380.96	Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear
32120		786.25	Thoracotomy, major; for postoperative complications
32124		839.95	Thoracotomy, major; with open intrapleural pneumonolysis
32140		912.11	Thoracotomy, major; with cyst(s) removal, with or without a pleural procedure
32141		910.47	Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure
32150		914.46	Thoracotomy, major; with removal of intrapleural foreign body or fibrin deposit
32151		929.27	Thoracotomy, major; with removal of intrapulmonary foreign body
32160		611.17	Thoracotomy, major; with cardiac massage
32200		993.66	Pneumonostomy; with open drainage of abscess or cyst
32201		211.86	Pneumonostomy; with percutaneous drainage of abscess or cyst
32215		768.47	Pleural scarification for repeat pneumothorax
32220		1,538.74	Decortication, pulmonary (separate procedure); total

Code	Group	Fee	40.06(8) – Surgical Services Description
32225		912.58	Decortication, pulmonary (separate procedure); partial
32310		880.21	Pleurectomy, parietal (separate procedure)
32320		1,509.22	Decortication and parietal pleurectomy
32400	01	140.43	Biopsy, pleura; percutaneous needle
32402		535.63	Biopsy, pleura; open
32405	01	166.29	Biopsy, lung or mediastinum, percutaneous needle
32420	01	121.09	Pneumocentesis, puncture of lung for aspiration
32440		1,580.22	Removal of lung, total pneumonectomy;
32442		1,725.48	Removal of lung, total pneumonectomy; with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)
32445		1,652.72	Removal of lung, total pneumonectomy; extrapleural
32480		1,485.98	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)
32482		1,572.85	Removal of lung, other than total pneumonectomy; two lobes (bilobectomy)
32484		1,353.09	Removal of lung, other than total pneumonectomy; single segment (segmentectomy)
32486		1,569.72	Removal of lung, other than total pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)
32488		1,666.58	Removal of lung, other than total pneumonectomy; all remaining lung following previous removal of a portion of lung (completion pneumonectomy)
32491		1,430.98	Removal of lung, other than total pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure
32500		1,415.08	Removal of lung, other than total pneumonectomy; wedge resection, single or multiple
32501		261.79	Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)
32520		1,393.35	Resection of lung; with resection of chest wall
32522		1,526.94	Resection of lung; with reconstruction of chest wall, without prosthesis
32525		1,657.46	Resection of lung; with major reconstruction of chest wall, with prosthesis
32540		1,025.94	Extrapleural enucleation of empyema (empyemectomy)
32601		330.32	Thoracoscopy, diagnostic (separate procedure); lungs and pleural space, without biopsy
32602		358.32	Thoracoscopy, diagnostic (separate procedure); lungs and pleural space, with biopsy
32603		451.98	Thoracoscopy, diagnostic (separate procedure); pericardial sac, without biopsy
32604		514.61	Thoracoscopy, diagnostic (separate procedure); pericardial sac, with biopsy
32605		417.34	Thoracoscopy, diagnostic (separate procedure); mediastinal space, without biopsy
32606		494.97	Thoracoscopy, diagnostic (separate procedure); mediastinal space, with biopsy
32650		736.56	Thoracoscopy, surgical; with pleurodesis (eg, mechanical or chemical)
32651		846.40	Thoracoscopy, surgical; with partial pulmonary decortication
32652		1,215.15	Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis
32653		836.15	Thoracoscopy, surgical; with removal of intrapleural foreign body or fibrin deposit
32654		842.04	Thoracoscopy, surgical; with control of traumatic hemorrhage
32655		855.18	Thoracoscopy, surgical; with excision-plication of bullae, including any pleural procedure
32656		880.22	Thoracoscopy, surgical; with parietal pleurectomy

Code	Group	Fee	40.06(8) – Surgical Services Description
32657		898.79	Thoracoscopy, surgical; with wedge resection of lung, single or multiple
32658		801.99	Thoracoscopy, surgical; with removal of clot or foreign body from pericardial sac
32659		802.42	Thoracoscopy, surgical; with creation of pericardial window or partial resection of pericardial sac for drainage
32660		1,133.03	Thoracoscopy, surgical; with total pericardiectomy
32661		888.94	Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass
32662		1,064.83	Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass
32663		1,233.52	Thoracoscopy, surgical; with lobectomy, total or segmental
32664		919.52	Thoracoscopy, surgical; with thoracic sympathectomy
32665		994.43	Thoracoscopy, surgical; with esophagomyotomy (Heller type)
32800		885.81	Repair lung hernia through chest wall
32810		867.39	Closure of chest wall following open flap drainage for empyema (Clagett type procedure)
32815		1,440.09	Open closure of major bronchial fistula
32820		1,410.62	Major reconstruction, chest wall (posttraumatic)
32850		I.C.	Donor pneumonectomy(ies) with preparation and maintenance of allograft (cadaver)
32851		2,810.74	Lung transplant, single; without cardiopulmonary bypass
32852		3,166.97	Lung transplant, single; with cardiopulmonary bypass
32853		3,369.12	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass
32854		3,625.36	Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass
32900		1,270.24	Resection of ribs, extrapleural, all stages
32905		1,302.66	Thoracoplasty, Schede type or extrapleural (all stages);
32906		1,639.09	Thoracoplasty, Schede type or extrapleural (all stages); with closure of bronchopleural fistula
32940		1,222.66	Pneumonolysis, extraperiosteal, including filling or packing procedures
32960		147.78	Pneumothorax, therapeutic, intrapleural injection of air
32997		326.19	Total lung lavage (unilateral)
32999		I.C.	Unlisted procedure, lungs and pleura
33010	02	129.74	Pericardiocentesis; initial
33011	02	131.42	Pericardiocentesis; subsequent
33015		489.07	Tube pericardiostomy
33020		817.38	Pericardiotomy for removal of clot or foreign body (primary procedure)
33025		778.80	Creation of pericardial window or partial resection for drainage
33030		1,195.34	Pericardiectomy, subtotal or complete; without cardiopulmonary bypass
33031		1,346.78	Pericardiectomy, subtotal or complete; with cardiopulmonary bypass
33050		936.45	Excision of pericardial cyst or tumor
33120		1,527.66	Excision of intracardiac tumor, resection with cardiopulmonary bypass
33130		1,325.47	Resection of external cardiac tumor
33140		1,296.40	Transmyocardial laser revascularization, by thoracotomy; (separate procedure)
33141		268.96	Transmyocardial laser revascularization, by thoracotomy; performed at the time of other open cardiac procedure(s) (List separately in addition to code for primary procedure)

Code	Group	Fee	40.06(8) – Surgical Services Description
33200		806.39	Insertion of permanent pacemaker with epicardial electrode(s); by thoracotomy
33201		710.61	Insertion of permanent pacemaker with epicardial electrode(s); by xiphoid approach
33206		461.79	Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial
33207		524.16	Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular
33208		530.57	Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular
33210		183.43	Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure)
33211		189.78	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)
33212		367.84	Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular
33213		415.67	Insertion or replacement of pacemaker pulse generator only; dual chamber
33214		521.12	Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)
33215		326.07	Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode
33216		411.75	Insertion of a transvenous electrode; single chamber (one electrode) permanent pacemaker or single chamber pacing cardioverter-defibrillator
33217		411.88	Insertion of a transvenous electrode; dual chamber (two electrodes) permanent pacemaker or dual chamber pacing cardioverter-defibrillator
33218		403.37	Repair of single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator
33220		404.83	Repair of two transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator
33222	02	384.55	Revision or relocation of skin pocket for pacemaker
33223	02	454.72	Revision of skin pocket for single or dual chamber pacing cardioverter-defibrillator
33224		523.26	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion and/or replacement of generator)
33225		463.18	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system) (List separately in addition to code for primary procedure)
33226		503.78	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of generator)
33233		271.69	Removal of permanent pacemaker pulse generator
33234		523.57	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular
33235		667.87	Removal of transvenous pacemaker electrode(s); dual lead system
33236		843.68	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular
33237		903.41	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; dual lead system
33238		977.76	Removal of permanent transvenous electrode(s) by thoracotomy
33240		501.85	Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator
33241		255.72	Subcutaneous removal of single or dual chamber pacing cardioverter-defibrillator pulse generator
33243		1,428.86	Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by thoracotomy

Code	Group	Fee	40.06(8) – Surgical Services Description
33244		933.92	Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by transvenous extraction
33245		923.18	Insertion of epicardial single or dual chamber pacing cardioverter-defibrillator electrodes by thoracotomy;
33246		1,299.03	Insertion of epicardial single or dual chamber pacing cardioverter-defibrillator electrodes by thoracotomy; with insertion of pulse generator
33249		922.54	Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator
33250		1,328.60	Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); without cardiopulmonary bypass
33251		1,518.87	Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); with cardiopulmonary bypass
33253		1,888.89	Operative incisions and reconstruction of atria for treatment of atrial fibrillation or atrial flutter (eg, maze procedure)
33261		1,538.20	Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass
33282		344.22	Implantation of patient-activated cardiac event recorder
33284		253.58	Removal of an implantable, patient-activated cardiac event recorder
33300		1,136.06	Repair of cardiac wound; without bypass
33305		1,355.28	Repair of cardiac wound; with cardiopulmonary bypass
33310		1,185.53	Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); without bypass
33315		1,408.98	Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); with cardiopulmonary bypass
33320		1,041.87	Suture repair of aorta or great vessels; without shunt or cardiopulmonary bypass
33321		1,274.01	Suture repair of aorta or great vessels; with shunt bypass
33322		1,307.40	Suture repair of aorta or great vessels; with cardiopulmonary bypass
33330		1,333.25	Insertion of graft, aorta or great vessels; without shunt, or cardiopulmonary bypass
33332		1,436.90	Insertion of graft, aorta or great vessels; with shunt bypass
33335		1,832.54	Insertion of graft, aorta or great vessels; with cardiopulmonary bypass
33400		1,848.16	Valvuloplasty, aortic valve; open, with cardiopulmonary bypass
33401		1,570.23	Valvuloplasty, aortic valve; open, with inflow occlusion
33403		1,632.51	Valvuloplasty, aortic valve; using transventricular dilation, with cardiopulmonary bypass
33404		1,808.99	Construction of apical-aortic conduit
33405		2,231.65	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve
33406		2,368.46	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)
33410		2,073.20	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve
33411		2,309.40	Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp
33412		2,614.24	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)
33413		2,673.32	Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)
33414		1,879.50	Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract
33415		1,650.35	Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis

Code	Group	Fee	40.06(8) – Surgical Services Description
33416		1,854.62	Ventriculomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hypertrophy)
33417		1,781.83	Aortoplasty (gusset) for supravalvular stenosis
33420		1,315.78	Valvotomy, mitral valve; closed heart
33422		1,673.97	Valvotomy, mitral valve; open heart, with cardiopulmonary bypass
33425		1,677.43	Valvuloplasty, mitral valve, with cardiopulmonary bypass;
33426		2,108.05	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring
33427		2,481.25	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring
33430		2,136.35	Replacement, mitral valve, with cardiopulmonary bypass
33460		1,477.31	Valvectomy, tricuspid valve, with cardiopulmonary bypass
33463		1,626.75	Valvuloplasty, tricuspid valve; without ring insertion
33464		1,728.04	Valvuloplasty, tricuspid valve; with ring insertion
33465		1,764.71	Replacement, tricuspid valve, with cardiopulmonary bypass
33468		1,858.51	Tricuspid valve repositioning and plication for Ebstein anomaly
33470		1,339.69	Valvotomy, pulmonary valve, closed heart; transventricular
33471		1,360.42	Valvotomy, pulmonary valve, closed heart; via pulmonary artery
33472		1,448.05	Valvotomy, pulmonary valve, open heart; with inflow occlusion
33474		1,432.15	Valvotomy, pulmonary valve, open heart; with cardiopulmonary bypass
33475		1,990.46	Replacement, pulmonary valve
33476		1,564.06	Right ventricular resection for infundibular stenosis, with or without commissurotomy
33478		1,688.98	Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection
33496		1,691.37	Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure)
33500		1,549.80	Repair of coronary arteriovenous or arteriocardiac chamber fistula; with cardiopulmonary bypass
33501		1,094.99	Repair of coronary arteriovenous or arteriocardiac chamber fistula; without cardiopulmonary bypass
33502		1,353.16	Repair of anomalous coronary artery; by ligation
33503		1,285.85	Repair of anomalous coronary artery; by graft, without cardiopulmonary bypass
33504		1,540.53	Repair of anomalous coronary artery; by graft, with cardiopulmonary bypass
33505		1,614.36	Repair of anomalous coronary artery; with construction of intrapulmonary artery tunnel (Takeuchi procedure)
33506		2,070.25	Repair of anomalous coronary artery; by translocation from pulmonary artery to aorta
33508		17.11	Endoscopy, surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure (List separately in addition to code for primary procedure)
33510		1,897.18	Coronary artery bypass, vein only; single coronary venous graft
33511		1,973.58	Coronary artery bypass, vein only; two coronary venous grafts
33512		2,076.32	Coronary artery bypass, vein only; three coronary venous grafts
33513		2,101.94	Coronary artery bypass, vein only; four coronary venous grafts
33514		2,155.82	Coronary artery bypass, vein only; five coronary venous grafts
33516		2,280.86	Coronary artery bypass, vein only; six or more coronary venous grafts

Code	Group	Fee	40.06(8) – Surgical Services Description
33517		144.02	Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for arterial graft)
33518		271.73	Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (List separately in addition to code for arterial graft)
33519		398.42	Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (List separately in addition to code for arterial graft)
33521		526.51	Coronary artery bypass, using venous graft(s) and arterial graft(s); four venous grafts (List separately in addition to code for arterial graft)
33522		654.03	Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (List separately in addition to code for arterial graft)
33523		781.57	Coronary artery bypass, using venous graft(s) and arterial graft(s); six or more venous grafts (List separately in addition to code for arterial graft)
33530		327.51	Reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation (List separately in addition to code for primary procedure)
33533		1,944.27	Coronary artery bypass, using arterial graft(s); single arterial graft
33534		2,093.64	Coronary artery bypass, using arterial graft(s); two coronary arterial grafts
33535		2,210.79	Coronary artery bypass, using arterial graft(s); three coronary arterial grafts
33536		2,305.71	Coronary artery bypass, using arterial graft(s); four or more coronary arterial grafts
33542		1,768.24	Myocardial resection (eg, ventricular aneurysmectomy)
33545		2,207.02	Repair of postinfarction ventricular septal defect, with or without myocardial resection
33572		248.77	Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)
33600		1,726.37	Closure of atrioventricular valve (mitral or tricuspid) by suture or patch
33602		1,708.30	Closure of semilunar valve (aortic or pulmonary) by suture or patch
33606		1,866.78	Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure)
33608		1,919.52	Repair of complex cardiac anomaly other than pulmonary atresia with ventricular septal defect by construction or replacement of conduit from right or left ventricle to pulmonary artery
33610		1,896.44	Repair of complex cardiac anomalies (eg, single ventricle with subaortic obstruction) by surgical enlargement of ventricular septal defect
33611		1,998.86	Repair of double outlet right ventricle with intraventricular tunnel repair;
33612		2,121.54	Repair of double outlet right ventricle with intraventricular tunnel repair; with repair of right ventricular outflow tract obstruction
33615		2,032.42	Repair of complex cardiac anomalies (eg, tricuspid atresia) by closure of atrial septal defect and anastomosis of atria or vena cava to pulmonary artery (simple Fontan procedure)
33617		2,219.95	Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure
33619		2,747.35	Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)
33641		1,308.41	Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch
33645		1,551.70	Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage
33647		1,787.90	Repair of atrial septal defect and ventricular septal defect, with direct or patch closure
33660		1,804.20	Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect), with or without atrioventricular valve repair
33665		1,801.30	Repair of intermediate or transitional atrioventricular canal, with or without atrioventricular valve repair

Code	Group	Fee	40.06(8) – Surgical Services Description
33670		1,961.29	Repair of complete atrioventricular canal, with or without prosthetic valve
33681		1,902.78	Closure of ventricular septal defect, with or without patch;
33684		1,830.96	Closure of ventricular septal defect, with or without patch; with pulmonary valvotomy or infundibular resection (acyanotic)
33688		1,739.42	Closure of ventricular septal defect, with or without patch; with removal of pulmonary artery band, with or without gusset
33690		1,263.79	Banding of pulmonary artery
33692		1,885.14	Complete repair tetralogy of Fallot without pulmonary atresia;
33694		2,038.33	Complete repair tetralogy of Fallot without pulmonary atresia; with transannular patch
33697		2,150.20	Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect
33702		1,657.31	Repair sinus of Valsalva fistula, with cardiopulmonary bypass;
33710		1,851.52	Repair sinus of Valsalva fistula, with cardiopulmonary bypass; with repair of ventricular septal defect
33720		1,637.14	Repair sinus of Valsalva aneurysm, with cardiopulmonary bypass
33722		1,794.80	Closure of aortico-left ventricular tunnel
33730		1,992.70	Complete repair of anomalous venous return (supracardiac, intracardiac, or infracardiac types)
33732		1,729.94	Repair of cor triatriatum or supravalvular mitral ring by resection of left atrial membrane
33735		1,270.89	Atrial septectomy or septostomy; closed heart (Blalock-Hanlon type operation)
33736		1,486.93	Atrial septectomy or septostomy; open heart with cardiopulmonary bypass
33737		1,389.83	Atrial septectomy or septostomy; open heart, with inflow occlusion
33750		1,303.83	Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation)
33755		1,299.91	Shunt; ascending aorta to pulmonary artery (Waterston type operation)
33762		1,309.81	Shunt; descending aorta to pulmonary artery (Potts-Smith type operation)
33764		1,325.05	Shunt; central, with prosthetic graft
33766		1,461.67	Shunt; superior vena cava to pulmonary artery for flow to one lung (classical Glenn procedure)
33767		1,533.87	Shunt; superior vena cava to pulmonary artery for flow to both lungs (bidirectional Glenn procedure)
33770		2,178.15	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect
33771		1,999.67	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; with surgical enlargement of ventricular septal defect
33774		1,917.35	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass;
33775		1,971.16	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with removal of pulmonary band
33776		2,116.69	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with closure of ventricular septal defect
33777		2,053.22	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with repair of subpulmonic obstruction
33778		2,396.74	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type);
33779		2,103.23	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with removal of pulmonary band
33780		2,566.85	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with closure of ventricular septal defect

Code	Group	Fee	40.06(8) – Surgical Services Description
33781		2,121.77	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with repair of subpulmonic obstruction
33786		2,345.92	Total repair, truncus arteriosus (Rastelli type operation)
33788		1,629.39	Reimplantation of an anomalous pulmonary artery
33800		997.93	Aortic suspension (aortopexy) for tracheal decompression (eg, for tracheomalacia) (separate procedure)
33802		1,113.24	Division of aberrant vessel (vascular ring);
33803		1,247.84	Division of aberrant vessel (vascular ring); with reanastomosis
33813		1,341.31	Obliteration of aortopulmonary septal defect; without cardiopulmonary bypass
33814		1,598.06	Obliteration of aortopulmonary septal defect; with cardiopulmonary bypass
33820		1,043.08	Repair of patent ductus arteriosus; by ligation
33822		1,116.92	Repair of patent ductus arteriosus; by division, under 18 years
33824		1,253.49	Repair of patent ductus arteriosus; by division, 18 years and older
33840		1,299.01	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis
33845		1,419.37	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with graft
33851		1,358.83	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; repair using either left subclavian artery or prosthetic material as gusset for enlargement
33852		1,490.71	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; without cardiopulmonary bypass
33853		1,976.14	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; with cardiopulmonary bypass
33860		2,284.00	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension;
33861		2,485.56	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with coronary reconstruction
33863		2,653.24	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction
33870		2,620.15	Transverse arch graft, with cardiopulmonary bypass
33875		1,990.09	Descending thoracic aorta graft, with or without bypass
33877		2,479.99	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass
33910		1,522.05	Pulmonary artery embolectomy; with cardiopulmonary bypass
33915		1,243.07	Pulmonary artery embolectomy; without cardiopulmonary bypass
33916		1,564.41	Pulmonary endarterectomy, with or without embolectomy, with cardiopulmonary bypass
33917		1,554.17	Repair of pulmonary artery stenosis by reconstruction with patch or graft
33918		1,633.32	Repair of pulmonary atresia with ventricular septal defect, by unifocalization of pulmonary arteries; without cardiopulmonary bypass
33919		2,374.84	Repair of pulmonary atresia with ventricular septal defect, by unifocalization of pulmonary arteries; with cardiopulmonary bypass
33920		1,920.18	Repair of pulmonary atresia with ventricular septal defect, by construction or replacement of conduit from right or left ventricle to pulmonary artery
33922		1,431.35	Transection of pulmonary artery with cardiopulmonary bypass
33924		311.70	Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)

Code	Group	Fee	40.06(8) – Surgical Services Description
33930		I.C.	Donor cardiectomy-pneumonectomy, with preparation and maintenance of allograft
33935		3,815.59	Heart-lung transplant with recipient cardiectomy-pneumonectomy
33940		I.C.	Donor cardiectomy, with preparation and maintenance of allograft
33945		2,694.50	Heart transplant, with or without recipient cardiectomy
33960		1,014.12	Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial 24 hours
33961		617.51	Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each additional 24 hours (List separately in addition to code for primary procedure)
33967		270.70	Insertion of intra-aortic balloon assist device, percutaneous
33968		36.23	Removal of intra-aortic balloon assist device, percutaneous
33970		375.89	Insertion of intra-aortic balloon assist device through the femoral artery, open approach
33971		655.99	Removal of intra-aortic balloon assist device including repair of femoral artery, with or without graft
33973		544.21	Insertion of intra-aortic balloon assist device through the ascending aorta
33974		931.45	Removal of intra-aortic balloon assist device from the ascending aorta, including repair of the ascending aorta, with or without graft
33975		1,118.85	Insertion of ventricular assist device; extracorporeal, single ventricle
33976		1,287.68	Insertion of ventricular assist device; extracorporeal, biventricular
33977		1,283.63	Removal of ventricular assist device; extracorporeal, single ventricle
33978		1,411.98	Removal of ventricular assist device; extracorporeal, biventricular
33979		2,507.01	Insertion of ventricular assist device, implantable intracorporeal, single ventricle
33980		3,360.38	Removal of ventricular assist device, implantable intracorporeal, single ventricle
33999		I.C.	Unlisted procedure, cardiac surgery
34001		823.40	Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate artery, by neck incision
34051		971.13	Embolectomy or thrombectomy, with or without catheter; innominate, subclavian artery, by thoracic incision
34101		643.69	Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision
34111		634.40	Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision
34151		1,448.33	Embolectomy or thrombectomy, with or without catheter; renal, celiac, mesentery, aortoiliac artery, by abdominal incision
34201		644.10	Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision
34203		1,011.97	Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision
34401		1,436.62	Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incision
34421		753.09	Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by leg incision
34451		1,558.60	Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision
34471		641.35	Thrombectomy, direct or with catheter; subclavian vein, by neck incision
34490		628.00	Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision
34501		1,012.50	Valvuloplasty, femoral vein
34502		1,643.21	Reconstruction of vena cava, any method

Code	Group	Fee	40.06(8) – Surgical Services Description
34510		1,170.97	Venous valve transposition, any vein donor
34520		1,094.33	Cross-over vein graft to venous system
34530		1,065.74	Saphenopopliteal vein anastomosis
34800		1,223.57	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis
34802		1,340.25	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)
34804		1,340.68	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis
34805		1,282.42	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis
34808		224.03	Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)
34812		366.28	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral
34813		259.53	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure)
34820		529.49	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral
34825		743.05	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel
34826		224.03	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure)
34830		1,891.70	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis
34831		1,919.67	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis
34832		2,041.08	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis
34833		667.07	Open iliac artery exposure with creation of conduit for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral
34834		313.07	Open brachial artery exposure to assist in the deployment of infrarenal aortic or iliac endovascular prosthesis by arm incision, unilateral
34900		1,000.56	Endovascular graft placement for repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma)
35001		1,231.91	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, carotid, subclavian artery, by neck incision
35002		1,267.33	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, carotid, subclavian artery, by neck incision
35005		1,105.81	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, vertebral artery
35011		1,062.81	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision
35013		1,307.62	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, axillary-brachial artery, by arm incision

Code	Group	Fee	40.06(8) – Surgical Services Description
35021		1,210.21	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, innominate, subclavian artery, by thoracic incision
35022		1,370.72	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, innominate, subclavian artery, by thoracic incision
35045		1,026.25	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery
35081		1,655.69	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta
35082		2,243.88	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta
35091		2,055.44	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)
35092		2,596.38	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)
35102		1,805.65	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)
35103		2,333.13	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)
35111		1,449.66	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, splenic artery
35112		1,706.54	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, splenic artery
35121		1,759.20	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, hepatic, celiac, renal, or mesenteric artery
35122		2,030.27	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, hepatic, celiac, renal, or mesenteric artery
35131		1,472.68	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, iliac artery (common, hypogastric, external)
35132		1,743.01	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, iliac artery (common, hypogastric, external)
35141		1,190.03	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral)
35142		1,379.19	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, common femoral artery (profunda femoris, superficial femoral)
35151		1,345.72	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery
35152		1,516.32	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, popliteal artery
35161		1,173.77	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or

Code	Group	Fee	40.06(8) – Surgical Services Description
			without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, other arteries
35162		1,229.94	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, other arteries
35180		859.27	Repair, congenital arteriovenous fistula; head and neck
35182		1,739.55	Repair, congenital arteriovenous fistula; thorax and abdomen
35184		1,077.80	Repair, congenital arteriovenous fistula; extremities
35188	04	916.54	Repair, acquired or traumatic arteriovenous fistula; head and neck
35189		1,636.99	Repair, acquired or traumatic arteriovenous fistula; thorax and abdomen
35190		802.03	Repair, acquired or traumatic arteriovenous fistula; extremities
35201		988.25	Repair blood vessel, direct; neck
35206		815.03	Repair blood vessel, direct; upper extremity
35207	04	740.26	Repair blood vessel, direct; hand, finger
35211		1,386.32	Repair blood vessel, direct; intrathoracic, with bypass
35216		1,165.57	Repair blood vessel, direct; intrathoracic, without bypass
35221		1,403.71	Repair blood vessel, direct; intra-abdominal
35226		893.33	Repair blood vessel, direct; lower extremity
35231		1,214.29	Repair blood vessel with vein graft; neck
35236		1,022.40	Repair blood vessel with vein graft; upper extremity
35241		1,447.80	Repair blood vessel with vein graft; intrathoracic, with bypass
35246		1,561.48	Repair blood vessel with vein graft; intrathoracic, without bypass
35251		1,703.84	Repair blood vessel with vein graft; intra-abdominal
35256		1,094.27	Repair blood vessel with vein graft; lower extremity
35261		1,058.03	Repair blood vessel with graft other than vein; neck
35266		901.09	Repair blood vessel with graft other than vein; upper extremity
35271		1,379.58	Repair blood vessel with graft other than vein; intrathoracic, with bypass
35276		1,474.22	Repair blood vessel with graft other than vein; intrathoracic, without bypass
35281		1,615.66	Repair blood vessel with graft other than vein; intra-abdominal
35286		1,000.11	Repair blood vessel with graft other than vein; lower extremity
35301		1,143.02	Thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision
35311		1,613.22	Thromboendarterectomy, with or without patch graft; subclavian, innominate, by thoracic incision
35321		964.15	Thromboendarterectomy, with or without patch graft; axillary-brachial
35331		1,560.05	Thromboendarterectomy, with or without patch graft; abdominal aorta
35341		1,509.05	Thromboendarterectomy, with or without patch graft; mesenteric, celiac, or renal
35351		1,355.33	Thromboendarterectomy, with or without patch graft; iliac
35355		1,103.87	Thromboendarterectomy, with or without patch graft; iliofemoral
35361		1,653.49	Thromboendarterectomy, with or without patch graft; combined aortoiliac
35363		1,769.52	Thromboendarterectomy, with or without patch graft; combined aortoiliofemoral
35371		896.68	Thromboendarterectomy, with or without patch graft; common femoral

Code	Group	Fee	40.06(8) – Surgical Services Description
35372		1,073.73	Thromboendarterectomy, with or without patch graft; deep (profunda) femoral
35381		991.42	Thromboendarterectomy, with or without patch graft; femoral and/or popliteal, and/or tibioperoneal
35390		179.19	Reoperation, carotid, thromboendarterectomy, more than one month after original operation (List separately in addition to code for primary procedure)
35400		172.64	Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (List separately in addition to code for primary procedure)
35450		579.58	Transluminal balloon angioplasty, open; renal or other visceral artery
35452		421.42	Transluminal balloon angioplasty, open; aortic
35454		371.40	Transluminal balloon angioplasty, open; iliac
35456		445.17	Transluminal balloon angioplasty, open; femoral-popliteal
35458		565.81	Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vessel
35459		513.29	Transluminal balloon angioplasty, open; tibioperoneal trunk and branches
35460		364.35	Transluminal balloon angioplasty, open; venous
35470		505.35	Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel
35471		584.57	Transluminal balloon angioplasty, percutaneous; renal or visceral artery
35472		410.87	Transluminal balloon angioplasty, percutaneous; aortic
35473		362.78	Transluminal balloon angioplasty, percutaneous; iliac
35474		412.97	Transluminal balloon angioplasty, percutaneous; femoral-popliteal
35475		545.73	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel
35476		357.43	Transluminal balloon angioplasty, percutaneous; venous
35480		647.97	Transluminal peripheral atherectomy, open; renal or other visceral artery
35481		463.58	Transluminal peripheral atherectomy, open; aortic
35482		407.64	Transluminal peripheral atherectomy, open; iliac
35483		483.69	Transluminal peripheral atherectomy, open; femoral-popliteal
35484		612.03	Transluminal peripheral atherectomy, open; brachiocephalic trunk or branches, each vessel
35485		567.02	Transluminal peripheral atherectomy, open; tibioperoneal trunk and branches
35490		635.41	Transluminal peripheral atherectomy, percutaneous; renal or other visceral artery
35491		443.40	Transluminal peripheral atherectomy, percutaneous; aortic
35492		400.46	Transluminal peripheral atherectomy, percutaneous; iliac
35493		482.78	Transluminal peripheral atherectomy, percutaneous; femoral-popliteal
35494		595.81	Transluminal peripheral atherectomy, percutaneous; brachiocephalic trunk or branches, each vessel
35495		561.14	Transluminal peripheral atherectomy, percutaneous; tibioperoneal trunk and branches
35500		351.22	Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure (List separately in addition to code for primary procedure)
35501		1,165.52	Bypass graft, with vein; carotid
35506		1,225.77	Bypass graft, with vein; carotid-subclavian
35507		1,221.57	Bypass graft, with vein; subclavian-carotid
35508		1,186.34	Bypass graft, with vein; carotid-vertebral
35509		1,128.01	Bypass graft, with vein; carotid-carotid

Code	Group	Fee	40.06(8) – Surgical Services Description
35510		1,357.88	Bypass graft, with vein; carotid-brachial
35511		1,257.12	Bypass graft, with vein; subclavian-subclavian
35512		1,331.86	Bypass graft, with vein; subclavian-brachial
35515		1,177.32	Bypass graft, with vein; subclavian-vertebral
35516		971.08	Bypass graft, with vein; subclavian-axillary
35518		1,243.03	Bypass graft, with vein; axillary-axillary
35521		1,318.07	Bypass graft, with vein; axillary-femoral
35522		1,293.00	Bypass graft, with vein; axillary-brachial
35525		1,233.94	Bypass graft, with vein; brachial-brachial
35526		1,736.24	Bypass graft, with vein; aortosubclavian or carotid
35531		2,081.40	Bypass graft, with vein; aortoceliac or aortomesenteric
35533		1,635.39	Bypass graft, with vein; axillary-femoral-femoral
35536		1,836.29	Bypass graft, with vein; splenorenal
35541		1,544.60	Bypass graft, with vein; aortoiliac or bi-iliac
35546		1,524.36	Bypass graft, with vein; aortofemoral or bifemoral
35548		1,299.51	Bypass graft, with vein; aortoiliofemoral, unilateral
35549		1,418.42	Bypass graft, with vein; aortoiliofemoral, bilateral
35551		1,606.97	Bypass graft, with vein; aortofemoral-popliteal
35556		1,320.94	Bypass graft, with vein; femoral-popliteal
35558		1,259.86	Bypass graft, with vein; femoral-femoral
35560		1,867.10	Bypass graft, with vein; aortorenal
35563		1,417.52	Bypass graft, with vein; ilioiliac
35565		1,364.23	Bypass graft, with vein; iliofemoral
35566		1,605.46	Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels
35571		1,443.07	Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels
35572		378.24	Harvest of femoropopliteal vein, one segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery) (List separately in addition to code for primary procedure)
35582		1,623.85	In-situ vein bypass; aortofemoral-popliteal (only femoral-popliteal portion in-situ)
35583		1,364.30	In-situ vein bypass; femoral-popliteal
35585		1,704.47	In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery
35587		1,496.84	In-situ vein bypass; popliteal-tibial, peroneal
35600		276.59	Harvest of upper extremity artery, one segment, for coronary artery bypass procedure
35601		1,099.11	Bypass graft, with other than vein; carotid
35606		1,164.90	Bypass graft, with other than vein; carotid-subclavian
35612		989.49	Bypass graft, with other than vein; subclavian-subclavian
35616		1,001.00	Bypass graft, with other than vein; subclavian-axillary
35621		1,181.11	Bypass graft, with other than vein; axillary-femoral
35623		1,416.81	Bypass graft, with other than vein; axillary-popliteal or -tibial

Code	Group	Fee	40.06(8) – Surgical Services Description
35626		1,656.71	Bypass graft, with other than vein; aortosubclavian or carotid
35631		1,967.62	Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal
35636		1,717.31	Bypass graft, with other than vein; splenorenal (splenic to renal arterial anastomosis)
35641		1,495.61	Bypass graft, with other than vein; aortoiliac or bi-iliac
35642		1,111.05	Bypass graft, with other than vein; carotid-vertebral
35645		1,076.93	Bypass graft, with other than vein; subclavian-vertebral
35646		1,852.79	Bypass graft, with other than vein; aortobifemoral
35647		1,671.38	Bypass graft, with other than vein; aortofemoral
35650		1,128.83	Bypass graft, with other than vein; axillary-axillary
35651		1,493.27	Bypass graft, with other than vein; aortofemoral-popliteal
35654		1,468.16	Bypass graft, with other than vein; axillary-femoral-femoral
35656		1,179.62	Bypass graft, with other than vein; femoral-popliteal
35661		1,147.34	Bypass graft, with other than vein; femoral-femoral
35663		1,306.95	Bypass graft, with other than vein; ilioiliac
35665		1,253.98	Bypass graft, with other than vein; iliofemoral
35666		1,366.71	Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery
35671		1,186.19	Bypass graft, with other than vein; popliteal-tibial or -peroneal artery
35681		89.27	Bypass graft; composite, prosthetic and vein (List separately in addition to code for primary procedure)
35682		402.29	Bypass graft; autogenous composite, two segments of veins from two locations (List separately in addition to code for primary procedure)
35683		474.84	Bypass graft; autogenous composite, three or more segments of vein from two or more locations (List separately in addition to code for primary procedure)
35685		218.25	Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to code for primary procedure)
35686		181.08	Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure)
35691		1,110.10	Transposition and/or reimplantation; vertebral to carotid artery
35693		970.66	Transposition and/or reimplantation; vertebral to subclavian artery
35694		1,162.67	Transposition and/or reimplantation; subclavian to carotid artery
35695		1,163.08	Transposition and/or reimplantation; carotid to subclavian artery
35697		168.84	Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery (List separately in addition to code for primary procedure)
35700		172.46	Reoperation, femoral-popliteal or femoral (popliteal)-anterior tibial, posterior tibial, peroneal artery or other distal vessels, more than one month after original operation (List separately in addition to code for primary procedure)
35701		561.61	Exploration (not followed by surgical repair), with or without lysis of artery; carotid artery
35721		480.52	Exploration (not followed by surgical repair), with or without lysis of artery; femoral artery
35741		521.44	Exploration (not followed by surgical repair), with or without lysis of artery; popliteal artery
35761		395.28	Exploration (not followed by surgical repair), with or without lysis of artery; other vessels
35800		490.12	Exploration for postoperative hemorrhage, thrombosis or infection; neck

Code	Group	Fee	40.06(8) – Surgical Services Description
35820		846.63	Exploration for postoperative hemorrhage, thrombosis or infection; chest
35840		630.27	Exploration for postoperative hemorrhage, thrombosis or infection; abdomen
35860		402.85	Exploration for postoperative hemorrhage, thrombosis or infection; extremity
35870		1,337.79	Repair of graft-enteric fistula
35875	09	637.22	Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula);
35876	09	1,027.96	Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); with revision of arterial or venous graft
35879		978.18	Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty
35881		1,098.68	Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition
35901		567.10	Excision of infected graft; neck
35903		644.25	Excision of infected graft; extremity
35905		1,813.19	Excision of infected graft; thorax
35907		1,991.34	Excision of infected graft; abdomen
36000		32.38	Introduction of needle or intracatheter, vein
36002		200.18	Injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm
36005		394.37	Injection procedure for extremity venography (including introduction of needle or intracatheter)
36010		130.64	Introduction of catheter, superior or inferior vena cava
36011		168.13	Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)
36012		187.14	Selective catheter placement, venous system; second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)
36013		129.15	Introduction of catheter, right heart or main pulmonary artery
36014		160.72	Selective catheter placement, left or right pulmonary artery
36015		186.54	Selective catheter placement, segmental or subsegmental pulmonary artery
36100		166.85	Introduction of needle or intracatheter, carotid or vertebral artery
36120		107.10	Introduction of needle or intracatheter; retrograde brachial artery
36140		106.97	Introduction of needle or intracatheter; extremity artery
36145		107.22	Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)
36160		138.06	Introduction of needle or intracatheter, aortic, translumbar
36200		162.28	Introduction of catheter, aorta
36215		250.81	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family
36216		281.62	Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family
36217		339.10	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family
36218		54.64	Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)
36245		254.06	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family

Code	Group	Fee	40.06(8) – Surgical Services Description
36246		283.49	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family
36247		337.42	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family
36248		54.94	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)
36260	03	608.63	Insertion of implantable intra-arterial infusion pump (eg, for chemotherapy of liver)
36261	02	377.42	Revision of implanted intra-arterial infusion pump
36262	01	283.58	Removal of implanted intra-arterial infusion pump
36299		I.C.	Unlisted procedure, vascular injection
36400		26.85	Venipuncture, under age 3 years, necessitating physicianÆs skill, not to be used for routine venipuncture; femoral or jugular vein
36405		23.37	Venipuncture, under age 3 years, necessitating physicianÆs skill, not to be used for routine venipuncture; scalp vein
36406		19.73	Venipuncture, under age 3 years, necessitating physicianÆs skill, not to be used for routine venipuncture; other vein
36410		19.73	Venipuncture, age 3 years or older, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
36415		I.C.	Collection of venous blood by venipuncture
36416		I.C.	Collection of capillary blood specimen (eg, finger, heel, ear stick)
36420		170.38	Venipuncture, cutdown; under age 1 year
36425		39.73	Venipuncture, cutdown; age 1 or over
36430		44.37	Transfusion, blood or blood components
36440		54.49	Push transfusion, blood, 2 years or under
36450		119.72	Exchange transfusion, blood; newborn
36455		138.23	Exchange transfusion, blood; other than newborn
36460		363.37	Transfusion, intrauterine, fetal
36468		I.C.	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk
36469		I.C.	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face
36470		159.36	Injection of sclerosing solution; single vein
36471		194.02	Injection of sclerosing solution; multiple veins, same leg
36481		594.19	Percutaneous portal vein catheterization by any method
36500		195.21	Venous catheterization for selective organ blood sampling
36510		200.86	Catheterization of umbilical vein for diagnosis or therapy, newborn
36511		97.64	Therapeutic apheresis; for white blood cells
36512		97.64	Therapeutic apheresis; for red blood cells
36513		97.64	Therapeutic apheresis; for platelets
36514		97.64	Therapeutic apheresis; for plasma pheresis
36515		98.49	Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion
36516		69.60	Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion

Code	Group	Fee	40.06(8) – Surgical Services Description
36522		1,343.90	Photopheresis, extracorporeal
36540		I.C.	Collection of blood specimen from a completely implantable venous access device
36550		27.53	Declotting by thrombolytic agent of implanted vascular access device or catheter
36555	01	360.28	Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age
36556	01	343.88	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older
36557	02	781.24	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age
36558	02	765.29	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older
36560	03	1,483.48	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; under 5 years of age
36561	03	1,470.68	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older
36563	03	1,859.46	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump
36565	03	1,177.29	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; without subcutaneous port or pump (eg, Tesio type catheter)
36566	03	1,229.86	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)
36568	01	423.94	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; under 5 years of age
36569	01	384.95	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older
36570	03	1,915.47	Insertion of peripherally inserted central venous access device, with subcutaneous port; under 5 years of age
36571	03	1,719.55	Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older
36575	02	184.17	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site
36576	02	462.99	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site
36578	02	593.60	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site
36580	01	339.16	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36581	02	706.42	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36582	03	1,335.97	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access
36583	03	768.77	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access
36584	01	354.82	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access
36585	03	1,693.10	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access
36589	01	185.84	Removal of tunneled central venous catheter, without subcutaneous port or pump
36590	01	406.94	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion

Code	Group	Fee	40.06(8) – Surgical Services Description
36595		974.63	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access
36596		214.84	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen
36597		181.78	Repositioning of previously placed central venous catheter under fluoroscopic guidance
36600		32.90	Arterial puncture, withdrawal of blood for diagnosis
36620		55.58	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
36625		107.19	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); cutdown
36640	01	130.05	Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown
36660		74.34	Catheterization, umbilical artery, newborn, for diagnosis or therapy
36680		68.91	Placement of needle for intraosseous infusion
36800	03	174.23	Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein
36810	03	234.97	Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external (Scribner type)
36815	03	157.42	Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external revision, or closure
36819	03	853.35	Arteriovenous anastomosis, open; by upper arm basilic vein transposition
36820	03	853.35	Arteriovenous anastomosis, open; by forearm vein transposition
36821	03	570.00	Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)
36822		416.07	Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)
36823		1,269.27	Insertion of arterial and venous cannula(s) for isolated extracorporeal circulation including regional chemotherapy perfusion to an extremity, with or without hyperthermia, with removal of cannula(s) and repair of arteriotomy and venotomy sites
36825	04	626.64	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft
36830	04	722.86	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)
36831	09	497.14	Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)
36832	04	637.90	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
36833	04	717.97	Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
36834		615.23	Plastic repair of arteriovenous aneurysm (separate procedure)
36835	04	483.09	Insertion of Thomas shunt (separate procedure)
36838		1,261.05	Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)
36860	02	184.36	External cannula declotting (separate procedure); without balloon catheter
36861	03	162.52	External cannula declotting (separate procedure); with balloon catheter
36870	09	2,183.00	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)
37140		1,374.86	Venous anastomosis, open; portocaval
37145		1,476.94	Venous anastomosis, open; renoportal

Code	Group	Fee	40.06(8) – Surgical Services Description
37160		1,283.71	Venous anastomosis, open; caval-mesenteric
37180		1,457.89	Venous anastomosis, open; splenorenal, proximal
37181		1,567.38	Venous anastomosis, open; splenorenal, distal (selective decompression of esophagogastric varices, any technique)
37182		958.22	Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)
37183		446.73	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)
37195		354.40	Thrombolysis, cerebral, by intravenous infusion
37200		241.71	Transcatheter biopsy
37201		303.10	Transcatheter therapy, infusion for thrombolysis other than coronary
37202		355.34	Transcatheter therapy, infusion other than for thrombolysis, any type (eg, spasmolytic, vasoconstrictive)
37203		304.35	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)
37204		965.90	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck
37205		485.11	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), percutaneous; initial vessel
37206		224.17	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), percutaneous; each additional vessel (List separately in addition to code for primary procedure)
37207		477.58	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; initial vessel
37208		229.85	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; each additional vessel (List separately in addition to code for primary procedure)
37209		121.12	Exchange of a previously placed arterial catheter during thrombolytic therapy
37250		117.10	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)
37251		88.62	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (List separately in addition to code for primary procedure)
37500		728.59	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)
37501		I.C.	Unlisted vascular endoscopy procedure
37565		663.90	Ligation, internal jugular vein
37600		719.05	Ligation; external carotid artery
37605		814.07	Ligation; internal or common carotid artery
37606		458.42	Ligation; internal or common carotid artery, with gradual occlusion, as with Selverstone or Crutchfield clamp
37607	03	407.54	Ligation or banding of angioaccess arteriovenous fistula
37609	02	318.75	Ligation or biopsy, temporal artery
37615		410.07	Ligation, major artery (eg, post-traumatic, rupture); neck
37616		1,034.51	Ligation, major artery (eg, post-traumatic, rupture); chest
37617		1,280.59	Ligation, major artery (eg, post-traumatic, rupture); abdomen
37618		352.96	Ligation, major artery (eg, post-traumatic, rupture); extremity

Code	Group	Fee	40.06(8) – Surgical Services Description
37620		665.58	Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)
37650	02	513.12	Ligation of femoral vein
37660		1,216.67	Ligation of common iliac vein
37700	02	273.13	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
37720	03	392.49	Ligation and division and complete stripping of long or short saphenous veins
37730	03	484.34	Ligation and division and complete stripping of long and short saphenous veins
37735	03	672.15	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia
37760	03	661.04	Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open
37765		482.99	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions
37766		586.45	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions
37780	03	280.53	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)
37785	03	375.79	Ligation, division, and/or excision of varicose vein cluster(s), one leg
37788		1,269.36	Penile revascularization, artery, with or without vein graft
37790	03	527.87	Penile venous occlusive procedure
37799		I.C.	Unlisted procedure, vascular surgery
38100		855.74	Splenectomy; total (separate procedure)
38101		903.74	Splenectomy; partial (separate procedure)
38102		267.88	Splenectomy; total, en bloc for extensive disease, in conjunction with other procedure (List in addition to code for primary procedure)
38115		928.93	Repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy
38120		1,015.82	Laparoscopy, surgical, splenectomy
38129		I.C.	Unlisted laparoscopy procedure, spleen
38200		141.27	Injection procedure for splenoportography
38204		I.C.	Management of recipient hematopoietic progenitor cell donor search and cell acquisition
38205		86.61	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic
38206		86.61	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
38207		I.C.	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage
38208		I.C.	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing
38209		I.C.	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing
38210		I.C.	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion
38211		I.C.	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion
38212		I.C.	Transplant preparation of hematopoietic progenitor cells; red blood cell removal
38213		I.C.	Transplant preparation of hematopoietic progenitor cells; platelet depletion
38214		I.C.	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion
38215		I.C.	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer

Code	Group	Fee	40.06(8) – Surgical Services Description
38220		209.70	Bone marrow; aspiration only
38221		229.79	Bone marrow; biopsy, needle or trocar
38230		309.66	Bone marrow harvesting for transplantation
38240		130.89	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic
38241		131.31	Bone marrow or blood-derived peripheral stem cell transplantation; autologous
38242		98.74	Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions
38300	01	266.76	Drainage of lymph node abscess or lymphadenitis; simple
38305	02	490.86	Drainage of lymph node abscess or lymphadenitis; extensive
38308	02	502.15	Lymphangiotomy or other operations on lymphatic channels
38380		546.23	Suture and/or ligation of thoracic duct; cervical approach
38381		834.77	Suture and/or ligation of thoracic duct; thoracic approach
38382		664.10	Suture and/or ligation of thoracic duct; abdominal approach
38500	02	310.57	Biopsy or excision of lymph node(s); open, superficial
38505	01	136.08	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)
38510	02	494.06	Biopsy or excision of lymph node(s); open, deep cervical node(s)
38520	02	443.30	Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad
38525	02	387.55	Biopsy or excision of lymph node(s); open, deep axillary node(s)
38530	02	511.35	Biopsy or excision of lymph node(s); open, internal mammary node(s)
38542	02	430.60	Dissection, deep jugular node(s)
38550	03	453.66	Excision of cystic hygroma, axillary or cervical; without deep neurovascular dissection
38555	04	948.61	Excision of cystic hygroma, axillary or cervical; with deep neurovascular dissection
38562		675.67	Limited lymphadenectomy for staging (separate procedure); pelvic and para-aortic
38564		669.45	Limited lymphadenectomy for staging (separate procedure); retroperitoneal (aortic and/or splenic)
38570	09	546.61	Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple
38571	09	817.68	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy
38572	09	969.30	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple
38589		I.C.	Unlisted laparoscopy procedure, lymphatic system
38700		672.97	Suprahyoid lymphadenectomy
38720		1,016.31	Cervical lymphadenectomy (complete)
38724		1,075.16	Cervical lymphadenectomy (modified radical neck dissection)
38740	02	613.56	Axillary lymphadenectomy; superficial
38745	04	786.87	Axillary lymphadenectomy; complete
38746		272.11	Thoracic lymphadenectomy, regional, including mediastinal and peritracheal nodes (List separately in addition to code for primary procedure)
38747		272.84	Abdominal lymphadenectomy, regional, including celiac, gastric, portal, peripancreatic, with or without para-aortic and vena caval nodes (List separately in addition to code for primary procedure)
38760	02	780.74	Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)
38765		1,182.61	Inguinofemoral lymphadenectomy, superficial, in continuity with pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)
38770		778.75	Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)

Code	Group	Fee	40.06(8) – Surgical Services Description
38780		1,031.35	Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)
38790		525.76	Injection procedure; lymphangiography
38792		39.66	Injection procedure; for identification of sentinel node
38794		317.06	Cannulation, thoracic duct
38999		I.C.	Unlisted procedure, hemic or lymphatic system
39000		454.17	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; cervical approach
39010		777.79	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; transthoracic approach, including either transthoracic or median sternotomy
39200		860.02	Excision of mediastinal cyst
39220		1,092.06	Excision of mediastinal tumor
39400		441.35	Mediastinoscopy, with or without biopsy
39499		I.C.	Unlisted procedure, mediastinum
39501		821.26	Repair, laceration of diaphragm, any approach
39502		979.43	Repair, paraesophageal hiatus hernia, transabdominal, with or without fundoplasty, vagotomy, and/or pyloroplasty, except neonatal
39503		5,119.35	Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia
39520		1,014.52	Repair, diaphragmatic hernia (esophageal hiatal); transthoracic
39530		943.84	Repair, diaphragmatic hernia (esophageal hiatal); combined, thoracoabdominal
39531		998.76	Repair, diaphragmatic hernia (esophageal hiatal); combined, thoracoabdominal, with dilation of stricture (with or without gastroplasty)
39540		816.47	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute
39541		877.85	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic
39545		880.72	Imbrication of diaphragm for eventration, transthoracic or transabdominal, paralytic or nonparalytic
39560		768.32	Resection, diaphragm; with simple repair (eg, primary suture)
39561		1,126.41	Resection, diaphragm; with complex repair (eg, prosthetic material, local muscle flap)
39599		I.C.	Unlisted procedure, diaphragm
40490		126.09	Biopsy of lip
40500	02	428.41	Vermilionectomy (lip shave), with mucosal advancement
40510	02	478.14	Excision of lip; transverse wedge excision with primary closure
40520	02	500.01	Excision of lip; V-excision with primary direct linear closure
40525	02	599.79	Excision of lip; full thickness, reconstruction with local flap (eg, Estlander or fan)
40527	02	704.51	Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)
40530	02	497.30	Resection of lip, more than one-fourth, without reconstruction
40650	03	381.94	Repair lip, full thickness; vermilion only
40652	03	448.36	Repair lip, full thickness; up to half vertical height
40654	03	519.08	Repair lip, full thickness; over one-half vertical height, or complex
40700	07	916.03	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral
40701	07	1,143.13	Plastic repair of cleft lip/nasal deformity; primary bilateral, one stage procedure
40702	01	884.62	Plastic repair of cleft lip/nasal deformity; primary bilateral, one of two stages
40720	07	1,000.21	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure

Code	Group	Fee	40.06(8) – Surgical Services Description
40761	03	1,061.42	Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle
40799		I.C.	Unlisted procedure, lips
40800		140.58	Drainage of abscess, cyst, hematoma, vestibule of mouth; simple
40801	02	235.63	Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated
40804		157.55	Removal of embedded foreign body, vestibule of mouth; simple
40805	02	250.64	Removal of embedded foreign body, vestibule of mouth; complicated
40806	01	70.04	Incision of labial frenum (frenotomy)
40808		135.13	Biopsy, vestibule of mouth
40810		153.03	Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair
40812		229.99	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair
40814	02	337.70	Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair
40816	02	354.89	Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle
40818	01	313.49	Excision of mucosa of vestibule of mouth as donor graft
40819	01	281.81	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)
40820		164.66	Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)
40830	01	200.88	Closure of laceration, vestibule of mouth; 2.5 cm or less
40831	01	252.44	Closure of laceration, vestibule of mouth; over 2.5 cm or complex
40840	02	719.00	Vestibuloplasty; anterior
40842	03	718.12	Vestibuloplasty; posterior, unilateral
40843	03	944.04	Vestibuloplasty; posterior, bilateral
40844	05	1,244.63	Vestibuloplasty; entire arch
40845	05	1,419.48	Vestibuloplasty; complex (including ridge extension, muscle repositioning)
40899		I.C.	Unlisted procedure, vestibule of mouth
41000	01	156.44	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual
41005	01	163.36	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial
41006	01	315.81	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, deep, supramylohyoid
41007	01	300.36	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submental space
41008	01	326.36	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space
41009	01	348.87	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space
41010	01	187.92	Incision of lingual frenum (frenotomy)
41015	01	385.40	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual
41016	01	393.04	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submental
41017	01	390.74	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular
41018	01	449.03	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space
41100		173.58	Biopsy of tongue; anterior two-thirds
41105	02	160.85	Biopsy of tongue; posterior one-third

Code	Group	Fee	40.06(8) – Surgical Services Description
41108	02	135.33	Biopsy of floor of mouth
41110	01	167.07	Excision of lesion of tongue without closure
41112	02	289.30	Excision of lesion of tongue with closure; anterior two-thirds
41113	02	322.60	Excision of lesion of tongue with closure; posterior one-third
41114	02	710.97	Excision of lesion of tongue with closure; with local tongue flap
41115	01	215.00	Excision of lingual frenum (frenectomy)
41116	01	276.20	Excision, lesion of floor of mouth
41120	05	712.77	Glossectomy; less than one-half tongue
41130		801.51	Glossectomy; hemiglossectomy
41135		1,554.72	Glossectomy; partial, with unilateral radical neck dissection
41140		1,703.97	Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection
41145		2,016.37	Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection
41150		1,580.95	Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection
41153		1,629.42	Glossectomy; composite procedure with resection floor of mouth, with suprahyoid neck dissection
41155		1,875.34	Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)
41250	02	206.84	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue
41251	02	243.11	Repair of laceration 2.5 cm or less; posterior one-third of tongue
41252	02	295.76	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex
41500	01	301.84	Fixation of tongue, mechanical, other than suture (eg, K-wire)
41510	01	267.97	Suture of tongue to lip for micrognathia (Douglas type procedure)
41520	02	281.41	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)
41599		I.C.	Unlisted procedure, tongue, floor of mouth
41800	01	159.55	Drainage of abscess, cyst, hematoma from dentoalveolar structures
41805	01	165.14	Removal of embedded foreign body from dentoalveolar structures; soft tissues
41806	01	262.13	Removal of embedded foreign body from dentoalveolar structures; bone
41820	01	I.C.	Gingivectomy, excision gingiva, each quadrant
41821		I.C.	Operculectomy, excision pericoronal tissues
41822		268.22	Excision of fibrous tuberosities, dentoalveolar structures
41823		380.28	Excision of osseous tuberosities, dentoalveolar structures
41825	01	190.84	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair
41826	01	255.70	Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair
41827	02	374.07	Excision of lesion or tumor (except listed above), dentoalveolar structures; with complex repair
41828		309.26	Excision of hyperplastic alveolar mucosa, each quadrant (specify)
41830	01	341.32	Alveolectomy, including curettage of osteitis or sequestrectomy
41850	01	I.C.	Destruction of lesion (except excision), dentoalveolar structures
41870		I.C.	Periodontal mucosal grafting
41872		299.44	Gingivoplasty, each quadrant (specify)
41874		322.20	Alveoloplasty, each quadrant (specify)
41899		I.C.	Unlisted procedure, dentoalveolar structures
42000	02	164.64	Drainage of abscess of palate, uvula

Code	Group	Fee	40.06(8) – Surgical Services Description
42100	02	148.69	Biopsy of palate, uvula
42104	02	182.39	Excision, lesion of palate, uvula; without closure
42106	02	241.70	Excision, lesion of palate, uvula; with simple primary closure
42107	02	434.63	Excision, lesion of palate, uvula; with local flap closure
42120	04	482.56	Resection of palate or extensive resection of lesion
42140	02	169.83	Uvulectomy, excision of uvula
42145	05	602.22	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
42160	01	224.01	Destruction of lesion, palate or uvula (thermal, cryo or chemical)
42180	01	243.65	Repair, laceration of palate; up to 2 cm
42182	02	332.26	Repair, laceration of palate; over 2 cm or complex
42200	05	866.66	Palatoplasty for cleft palate, soft and/or hard palate only
42205	05	924.24	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only
42210	05	1,034.48	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)
42215	07	685.27	Palatoplasty for cleft palate; major revision
42220	05	516.79	Palatoplasty for cleft palate; secondary lengthening procedure
42225	05	709.27	Palatoplasty for cleft palate; attachment pharyngeal flap
42226	05	735.29	Lengthening of palate, and pharyngeal flap
42227	01	693.22	Lengthening of palate, with island flap
42235	05	539.62	Repair of anterior palate, including vomer flap
42260	04	789.15	Repair of nasolabial fistula
42280		146.58	Maxillary impression for palatal prosthesis
42281	03	200.97	Insertion of pin-retained palatal prosthesis
42299		I.C.	Unlisted procedure, palate, uvula
42300	01	202.53	Drainage of abscess; parotid, simple
42305	02	453.68	Drainage of abscess; parotid, complicated
42310	01	161.37	Drainage of abscess; submaxillary or sublingual, intraoral
42320	01	243.30	Drainage of abscess; submaxillary, external
42325	02	259.23	Fistulization of sublingual salivary cyst (ranula);
42326	02	345.84	Fistulization of sublingual salivary cyst (ranula); with prosthesis
42330	03	228.15	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral
42335		297.62	Sialolithotomy; submandibular (submaxillary), complicated, intraoral
42340	02	402.06	Sialolithotomy; parotid, extraoral or complicated intraoral
42400	01	105.28	Biopsy of salivary gland; needle
42405	02	308.55	Biopsy of salivary gland; incisional
42408	03	396.00	Excision of sublingual salivary cyst (ranula)
42409	03	262.81	Marsupialization of sublingual salivary cyst (ranula)
42410	03	659.63	Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection
42415	07	1,156.03	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve
42420	07	1,328.40	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve
42425	07	907.95	Excision of parotid tumor or parotid gland; total, en bloc removal with sacrifice of facial nerve
42426		1,423.39	Excision of parotid tumor or parotid gland; total, with unilateral radical neck dissection

Code	Group	Fee	40.06(8) – Surgical Services Description
42440	03	494.35	Excision of submandibular (submaxillary) gland
42450	02	424.73	Excision of sublingual gland
42500	03	402.73	Plastic repair of salivary duct, sialodochoplasty; primary or simple
42505	04	539.43	Plastic repair of salivary duct, sialodochoplasty; secondary or complicated
42507	03	473.22	Parotid duct diversion, bilateral (Wilke type procedure);
42508	04	661.80	Parotid duct diversion, bilateral (Wilke type procedure); with excision of one submandibular gland
42509	04	834.34	Parotid duct diversion, bilateral (Wilke type procedure); with excision of both submandibular glands
42510	04	585.21	Parotid duct diversion, bilateral (Wilke type procedure); with ligation of both submandibular (Wharton's) ducts
42550		599.35	Injection procedure for sialography
42600	01	439.44	Closure salivary fistula
42650		80.46	Dilation salivary duct
42660		107.40	Dilation and catheterization of salivary duct, with or without injection
42665		251.77	Ligation salivary duct, intraoral
42699		I.C.	Unlisted procedure, salivary glands or ducts
42700	01	180.79	Incision and drainage abscess; peritonsillar
42720	01	430.56	Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach
42725	02	769.52	Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach
42800	01	150.02	Biopsy; oropharynx
42802	01	246.61	Biopsy; hypopharynx
42804	01	217.41	Biopsy; nasopharynx, visible lesion, simple
42806	02	237.03	Biopsy; nasopharynx, survey for unknown primary lesion
42808	02	226.66	Excision or destruction of lesion of pharynx, any method
42809		172.54	Removal of foreign body from pharynx
42810	03	335.58	Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues
42815	05	513.90	Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues and/or into pharynx
42820	03	303.54	Tonsillectomy and adenoidectomy; under age 12
42821	05	327.32	Tonsillectomy and adenoidectomy; age 12 or over
42825	04	277.24	Tonsillectomy, primary or secondary; under age 12
42826	04	270.79	Tonsillectomy, primary or secondary; age 12 or over
42830	04	213.96	Adenoidectomy, primary; under age 12
42831	04	229.65	Adenoidectomy, primary; age 12 or over
42835	04	203.47	Adenoidectomy, secondary; under age 12
42836	04	260.38	Adenoidectomy, secondary; age 12 or over
42842		636.27	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure
42844		999.17	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (eg, tongue, buccal)
42845		1,657.15	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap
42860	03	198.17	Excision of tonsil tags
42870	03	418.97	Excision or destruction lingual tonsil, any method (separate procedure)
42890	07	913.92	Limited pharyngectomy
42892	07	1,096.34	Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and

Code	Group	Fee	40.06(8) – Surgical Services Description
			posterior pharyngeal walls
42894		1,556.32	Resection of pharyngeal wall requiring closure with myocutaneous flap
42900	01	367.67	Suture pharynx for wound or injury
42950	02	604.28	Pharyngoplasty (plastic or reconstructive operation on pharynx)
42953		681.31	Pharyngoesophageal repair
42955	02	536.31	Pharyngostomy (fistulization of pharynx, external for feeding)
42960	01	178.47	Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); simple
42961		429.26	Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); complicated, requiring hospitalization
42962	02	529.01	Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); with secondary surgical intervention
42970		370.06	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cautery
42971		459.50	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); complicated, requiring hospitalization
42972	03	521.21	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); with secondary surgical intervention
42999		I.C.	Unlisted procedure, pharynx, adenoids, or tonsils
43020		570.17	Esophagotomy, cervical approach, with removal of foreign body
43030		556.54	Cricopharyngeal myotomy
43045		1,288.84	Esophagotomy, thoracic approach, with removal of foreign body
43100		638.97	Excision of lesion, esophagus, with primary repair; cervical approach
43101		1,011.73	Excision of lesion, esophagus, with primary repair; thoracic or abdominal approach
43107		2,347.71	Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)
43108		2,026.96	Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)
43112		2,539.49	Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty
43113		2,125.42	Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43116		1,978.80	Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction
43117		2,323.47	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)
43118		1,963.41	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43121		1,761.16	Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty
43122		2,319.42	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty
43123		1,991.17	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)

Code	Group	Fee	40.06(8) – Surgical Services Description
43124		1,690.23	Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy
43130		801.94	Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach
43135		1,017.22	Diverticulectomy of hypopharynx or esophagus, with or without myotomy; thoracic approach
43200	01	232.90	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43201	01	281.14	Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance
43202	01	302.26	Esophagoscopy, rigid or flexible; with biopsy, single or multiple
43204	01	213.31	Esophagoscopy, rigid or flexible; with injection sclerosis of esophageal varices
43205	01	214.18	Esophagoscopy, rigid or flexible; with band ligation of esophageal varices
43215	01	155.77	Esophagoscopy, rigid or flexible; with removal of foreign body
43216	01	145.64	Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
43217	01	401.88	Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43219	01	169.04	Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent
43220	01	125.12	Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter)
43226	01	137.12	Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire
43227	02	203.94	Esophagoscopy, rigid or flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
43228	02	217.39	Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
43231	02	183.56	Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination
43232	02	255.42	Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)
43234	01	300.22	Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)
43235	01	307.38	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43236	02	381.63	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance
43237		226.05	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus
43238		280.45	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)
43239	02	348.55	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple
43240	02	382.92	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst
43241	02	150.82	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic intraluminal tube or catheter placement
43242	02	402.97	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate)

Code	Group	Fee	40.06(8) – Surgical Services Description
43243	02	257.02	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with injection sclerosis of esophageal and/or gastric varices
43244	02	282.29	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices
43245	02	183.00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction (eg, balloon, guide wire, bougie)
43246	02	244.95	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube
43247	02	193.62	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body
43248	02	181.09	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire
43249	02	167.45	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)
43250	02	183.88	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
43251	02	210.54	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43255	02	269.52	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method
43256	03	246.67	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)
43258	03	256.87	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
43259	03	289.81	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate
43260	02	331.65	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43261	02	348.58	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple
43262	02	409.05	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy
43263	02	401.92	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)
43264	02	491.16	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts
43265	02	549.63	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method
43267	02	408.63	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube
43268	02	412.84	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct
43269	02	450.10	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent
43271	02	408.63	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)

Code	Group	Fee	40.06(8) – Surgical Services Description
43272	02	409.05	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
43280		1,021.93	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)
43289		I.C.	Unlisted laparoscopy procedure, esophagus
43300		649.60	Esophagoplasty (plastic repair or reconstruction), cervical approach; without repair of tracheoesophageal fistula
43305		1,158.25	Esophagoplasty (plastic repair or reconstruction), cervical approach; with repair of tracheoesophageal fistula
43310		1,541.11	Esophagoplasty (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula
43312		1,698.41	Esophagoplasty (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula
43313		2,750.69	Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula
43314		3,022.18	Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; with repair of congenital tracheoesophageal fistula
43320		1,198.78	Esophagogastrostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach
43324		1,208.44	Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)
43325		1,187.65	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)
43326		1,203.56	Esophagogastric fundoplasty; with gastroplasty (eg, Collis)
43330		1,161.38	Esophagomyotomy (Heller type); abdominal approach
43331		1,242.22	Esophagomyotomy (Heller type); thoracic approach
43340		1,174.49	Esophagojejunostomy (without total gastrectomy); abdominal approach
43341		1,286.56	Esophagojejunostomy (without total gastrectomy); thoracic approach
43350		994.31	Esophagostomy, fistulization of esophagus, external; abdominal approach
43351		1,160.64	Esophagostomy, fistulization of esophagus, external; thoracic approach
43352		977.09	Esophagostomy, fistulization of esophagus, external; cervical approach
43360		2,091.56	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty
43361		2,368.22	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)
43400		1,231.53	Ligation, direct, esophageal varices
43401		1,297.55	Transection of esophagus with repair, for esophageal varices
43405		1,218.05	Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation
43410		873.05	Suture of esophageal wound or injury; cervical approach
43415		1,508.24	Suture of esophageal wound or injury; transthoracic or transabdominal approach
43420		886.89	Closure of esophagostomy or fistula; cervical approach
43425		1,288.19	Closure of esophagostomy or fistula; transthoracic or transabdominal approach
43450	01	160.67	Dilation of esophagus, by unguided sound or bougie, single or multiple passes
43453	01	310.76	Dilation of esophagus, over guide wire
43456	02	681.63	Dilation of esophagus, by balloon or dilator, retrograde

Code	Group	Fee	40.06(8) – Surgical Services Description
43458	02	397.80	Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia
43460		213.23	Esophagogastric tamponade, with balloon (Sengstaaken type)
43496		I.C.	Free jejunum transfer with microvascular anastomosis
43499		I.C.	Unlisted procedure, esophagus
43500		657.00	Gastrotomy; with exploration or foreign body removal
43501		1,163.07	Gastrotomy; with suture repair of bleeding ulcer
43502		1,338.26	Gastrotomy; with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss)
43510		802.98	Gastrotomy; with esophageal dilation and insertion of permanent intraluminal tube (eg, Celestin or Mousseaux-Barbin)
43520		630.05	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)
43600	01	119.34	Biopsy of stomach; by capsule, tube, peroral (one or more specimens)
43605		708.86	Biopsy of stomach; by laparotomy
43610		852.25	Excision, local; ulcer or benign tumor of stomach
43611		1,042.19	Excision, local; malignant tumor of stomach
43620		1,714.06	Gastrectomy, total; with esophagoenterostomy
43621		1,750.79	Gastrectomy, total; with Roux-en-Y reconstruction
43622		1,848.16	Gastrectomy, total; with formation of intestinal pouch, any type
43631		1,310.95	Gastrectomy, partial, distal; with gastroduodenostomy
43632		1,311.25	Gastrectomy, partial, distal; with gastrojejunostomy
43633		1,339.03	Gastrectomy, partial, distal; with Roux-en-Y reconstruction
43634		1,452.08	Gastrectomy, partial, distal; with formation of intestinal pouch
43635		114.69	Vagotomy when performed with partial distal gastrectomy (List separately in addition to code(s) for primary procedure)
43638		1,676.37	Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrostomy, with vagotomy;
43639		1,695.15	Gastrectomy, partial, proximal, thoracic or abdominal approach including esophagogastrostomy, with vagotomy; with pyloroplasty or pyloromyotomy
43640		1,003.00	Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective
43641		1,017.96	Vagotomy including pyloroplasty, with or without gastrostomy; parietal cell (highly selective)
43651		621.53	Laparoscopy, surgical; transection of vagus nerves, truncal
43652		730.34	Laparoscopy, surgical; transection of vagus nerves, selective or highly selective
43653	09	497.20	Laparoscopy, surgical; gastrostomy, without construction of gastric tube (eg, Stamm procedure) (separate procedure)
43659		I.C.	Unlisted laparoscopy procedure, stomach
43750	02	295.60	Percutaneous placement of gastrostomy tube
43752		37.20	Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)
43760	01	113.43	Change of gastrostomy tube
43761		112.70	Repositioning of the gastric feeding tube, any method, through the duodenum for enteric nutrition
43800		804.58	Pyloroplasty
43810		854.20	Gastroduodenostomy

Code	Group	Fee	40.06(8) – Surgical Services Description
43820		893.33	Gastrojejunostomy; without vagotomy
43825		1,117.70	Gastrojejunostomy; with vagotomy, any type
43830		589.60	Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)
43831		516.04	Gastrostomy, open; neonatal, for feeding
43832		919.17	Gastrostomy, open; with construction of gastric tube (eg, Janeway procedure)
43840		916.57	Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury
43842		1,093.51	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843		1,099.93	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
43846		1,413.33	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy
43847		1,568.20	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43848		1,709.54	Revision of gastric restrictive procedure for morbid obesity (separate procedure)
43850		1,418.12	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy
43855		1,495.12	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; with vagotomy
43860		1,437.52	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy
43865		1,521.38	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy
43870	01	582.63	Closure of gastrostomy, surgical
43880		1,418.49	Closure of gastrocolic fistula
43999		I.C.	Unlisted procedure, stomach
44005		947.04	Enterolysis (freeing of intestinal adhesion) (separate procedure)
44010		741.31	Duodenotomy, for exploration, biopsy(s), or foreign body removal
44015		145.31	Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method (List separately in addition to primary procedure)
44020		822.37	Enterotomy, small intestine, other than duodenum; for exploration, biopsy(s), or foreign body removal
44021		826.55	Enterotomy, small intestine, other than duodenum; for decompression (eg, Baker tube)
44025		837.40	Colotomy, for exploration, biopsy(s), or foreign body removal
44050		822.93	Reduction of volvulus, intussusception, internal hernia, by laparotomy
44055		1,246.29	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (eg, Ladd procedure)
44100	01	126.37	Biopsy of intestine by capsule, tube, peroral (one or more specimens)
44110		703.04	Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy
44111		842.30	Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; multiple enterotomies
44120		992.86	Enterectomy, resection of small intestine; single resection and anastomosis
44121		248.42	Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)

Code	Group	Fee	40.06(8) – Surgical Services Description
44125		1,022.43	Enterectomy, resection of small intestine; with enterostomy
44126		1,946.64	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; without tapering
44127		2,224.18	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; with tapering
44128		248.54	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)
44130		853.93	Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)
44132		I.C.	Donor enterectomy, open, with preparation and maintenance of allograft; from cadaver donor
44133		I.C.	Donor enterectomy, open, with preparation and maintenance of allograft; partial, from living donor
44135		I.C.	Intestinal allotransplantation; from cadaver donor
44136		I.C.	Intestinal allotransplantation; from living donor
44139		123.63	Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)
44140		1,234.47	Colectomy, partial; with anastomosis
44141		1,232.93	Colectomy, partial; with skin level cecostomy or colostomy
44143		1,394.26	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)
44144		1,287.61	Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula
44145		1,533.37	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)
44146		1,663.66	Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy
44147		1,211.25	Colectomy, partial; abdominal and transanal approach
44150		1,488.31	Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy
44151		1,654.28	Colectomy, total, abdominal, without proctectomy; with continent ileostomy
44152		1,625.79	Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, with or without loop ileostomy
44153		1,849.70	Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy
44155		1,697.51	Colectomy, total, abdominal, with proctectomy; with ileostomy
44156		1,879.12	Colectomy, total, abdominal, with proctectomy; with continent ileostomy
44160		1,097.00	Colectomy, partial, with removal of terminal ileum with ileocolostomy
44200		859.18	Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion) (separate procedure)
44201		601.64	Laparoscopy, surgical; jejunostomy (eg, for decompression or feeding)
44202		1,286.81	Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis
44203		247.16	Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)
44204		1,458.16	Laparoscopy, surgical; colectomy, partial, with anastomosis
44205		1,292.16	Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy
44206		1,569.13	Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)
44207		1,698.73	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic

Code	Group	Fee	40.06(8) – Surgical Services Description
			anastomosis)
44208		1,843.69	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy
44210		1,635.56	Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy
44211		2,023.59	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy
44212		1,890.66	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy
44238		I.C.	Unlisted laparoscopy procedure, intestine (except rectum)
44239		I.C.	Unlisted laparoscopy procedure, rectum
44300		720.82	Enterostomy or cecostomy, tube (eg, for decompression or feeding) (separate procedure)
44310		925.20	Ileostomy or jejunostomy, non-tube (separate procedure)
44312	01	491.43	Revision of ileostomy; simple (release of superficial scar) (separate procedure)
44314		880.69	Revision of ileostomy; complicated (reconstruction in-depth) (separate procedure)
44316		1,207.68	Continent ileostomy (Kock procedure) (separate procedure)
44320		1,035.27	Colostomy or skin level cecostomy; (separate procedure)
44322		860.33	Colostomy or skin level cecostomy; with multiple biopsies (eg, for congenital megacolon) (separate procedure)
44340	03	492.82	Revision of colostomy; simple (release of superficial scar) (separate procedure)
44345		913.43	Revision of colostomy; complicated (reconstruction in-depth) (separate procedure)
44346		996.25	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)
44360	02	149.98	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44361	02	164.63	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple
44363	02	197.52	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body
44364	02	212.23	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
44365	02	189.59	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
44366	02	248.21	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44369	02	252.66	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44370	09	272.02	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation)
44372	02	249.59	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with placement of percutaneous jejunostomy tube
44373	02	199.63	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube
44376	02	294.47	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44377	02	308.99	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with

Code	Group	Fee	40.06(8) – Surgical Services Description
			biopsy, single or multiple
44378	02	396.23	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44379	09	418.63	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation)
44380	01	66.20	Ileoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44382	01	78.59	Ileoscopy, through stoma; with biopsy, single or multiple
44383	09	169.62	Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)
44385	01	282.76	Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44386	01	359.77	Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; with biopsy, single or multiple
44388	01	329.61	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44389	01	398.21	Colonoscopy through stoma; with biopsy, single or multiple
44390	01	437.11	Colonoscopy through stoma; with removal of foreign body
44391	01	533.87	Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44392	01	427.34	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
44393	01	482.90	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44394	01	502.67	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
44397		274.27	Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)
44500		34.25	Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)
44602		913.05	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation
44603		1,061.07	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; multiple perforations
44604		928.60	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy
44605		1,147.75	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); with colostomy
44615		933.62	Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction
44620		723.34	Closure of enterostomy, large or small intestine;
44625		881.54	Closure of enterostomy, large or small intestine; with resection and anastomosis other than colorectal
44626		1,462.34	Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)
44640		1,231.44	Closure of intestinal cutaneous fistula
44650		1,280.40	Closure of enteroenteric or enterocolic fistula
44660		1,199.54	Closure of enterovesical fistula; without intestinal or bladder resection
44661		1,394.24	Closure of enterovesical fistula; with intestine and/or bladder resection

Code	Group	Fee	40.06(8) – Surgical Services Description
44680		902.62	Intestinal plication (separate procedure)
44700		932.55	Exclusion of small intestine from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum)
44701		169.08	Intraoperative colonic lavage (List separately in addition to code for primary procedure)
44799		I.C.	Unlisted procedure, intestine
44800		691.81	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct
44820		725.46	Excision of lesion of mesentery (separate procedure)
44850		652.39	Suture of mesentery (separate procedure)
44899		I.C.	Unlisted procedure, Meckel's diverticulum and the mesentery
44900		611.72	Incision and drainage of appendiceal abscess; open
44901		180.59	Incision and drainage of appendiceal abscess; percutaneous
44950		591.88	Appendectomy;
44955		85.74	Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)
44960		730.66	Appendectomy; for ruptured appendix with abscess or generalized peritonitis
44970		537.80	Laparoscopy, surgical, appendectomy
44979		I.C.	Unlisted laparoscopy procedure, appendix
45000	01	309.19	Transrectal drainage of pelvic abscess
45005	02	285.67	Incision and drainage of submucosal abscess, rectum
45020	02	331.84	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess
45100	01	251.14	Biopsy of anorectal wall, anal approach (eg, congenital megacolon)
45108	02	318.28	Anorectal myomectomy
45110		1,663.17	Proctectomy; complete, combined abdominoperineal, with colostomy
45111		982.51	Proctectomy; partial resection of rectum, transabdominal approach
45112		1,732.91	Proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis)
45113		1,763.30	Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy
45114		1,575.31	Proctectomy, partial, with anastomosis; abdominal and transsacral approach
45116		1,422.59	Proctectomy, partial, with anastomosis; transsacral approach only (Kraske type)
45119		1,766.78	Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with or without proximal diverting ostomy
45120		1,438.18	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull-through procedure and anastomosis (eg, Swenson, Duhamel, or Soave type operation)
45121		1,585.71	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with subtotal or total colectomy, with multiple biopsies
45123		957.36	Proctectomy, partial, without anastomosis, perineal approach
45126		2,634.25	Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof
45130		946.33	Excision of rectal procidentia, with anastomosis; perineal approach
45135		1,138.26	Excision of rectal procidentia, with anastomosis; abdominal and perineal approach
45136		1,654.10	Excision of ileoanal reservoir with ileostomy

Code	Group	Fee	40.06(8) – Surgical Services Description
45150	02	355.55	Division of stricture of rectum
45160	02	897.24	Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach
45170	02	686.77	Excision of rectal tumor, transanal approach
45190	09	591.79	Destruction of rectal tumor (eg, electrodessication, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach
45300		78.10	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45303		821.30	Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)
45305	01	150.14	Proctosigmoidoscopy, rigid; with biopsy, single or multiple
45307	01	167.31	Proctosigmoidoscopy, rigid; with removal of foreign body
45308	01	117.88	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
45309	01	198.86	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique
45315	01	178.02	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
45317	01	164.09	Proctosigmoidoscopy, rigid; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45320	01	186.50	Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (eg, laser)
45321	01	74.87	Proctosigmoidoscopy, rigid; with decompression of volvulus
45327		95.33	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)
45330		130.74	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45331	01	168.43	Sigmoidoscopy, flexible; with biopsy, single or multiple
45332	01	276.27	Sigmoidoscopy, flexible; with removal of foreign body
45333	01	270.67	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45334	01	158.39	Sigmoidoscopy, flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45335	01	202.47	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
45337	01	138.66	Sigmoidoscopy, flexible; with decompression of volvulus, any method
45338	01	305.67	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45339	01	265.50	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45340	01	356.95	Sigmoidoscopy, flexible; with dilation by balloon, 1 or more strictures
45341		152.46	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
45342		228.57	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45345		166.10	Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)
45355	01	200.67	Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple
45378	02	400.96	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	02	504.16	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
45380	02	472.58	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45381	02	508.64	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance

Code	Group	Fee	40.06(8) – Surgical Services Description
45382	02	633.83	Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45383	02	563.59	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45384	02	467.57	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	02	534.22	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386	02	755.23	Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more strictures
45387		333.55	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)
45500	02	446.25	Proctoplasty; for stenosis
45505	02	466.60	Proctoplasty; for prolapse of mucous membrane
45520		58.07	Perirectal injection of sclerosing solution for prolapse
45540		944.25	Proctopexy for prolapse; abdominal approach
45541		789.27	Proctopexy for prolapse; perineal approach
45550		1,315.09	Proctopexy combined with sigmoid resection, abdominal approach
45560	02	640.44	Repair of rectocele (separate procedure)
45562		918.10	Exploration, repair, and presacral drainage for rectal injury;
45563		1,397.38	Exploration, repair, and presacral drainage for rectal injury; with colostomy
45800		1,026.22	Closure of rectovesical fistula;
45805		1,240.24	Closure of rectovesical fistula; with colostomy
45820		1,062.62	Closure of rectourethral fistula;
45825		1,253.05	Closure of rectourethral fistula; with colostomy
45900	01	168.80	Reduction of procidentia (separate procedure) under anesthesia
45905	01	152.11	Dilation of anal sphincter (separate procedure) under anesthesia other than local
45910	01	180.66	Dilation of rectal stricture (separate procedure) under anesthesia other than local
45915	01	324.10	Removal of fecal impaction or foreign body (separate procedure) under anesthesia
45999		I.C.	Unlisted procedure, rectum
46020	03	213.57	Placement of seton
46030	01	107.19	Removal of anal seton, other marker
46040	03	427.47	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)
46045	02	300.01	Incision and drainage of intramural, intramuscular, or submucosal abscess, transanal, under anesthesia
46050	01	157.11	Incision and drainage, perianal abscess, superficial
46060	02	372.19	Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton
46070	05	191.34	Incision, anal septum (infant)
46080	03	203.04	Sphincterotomy, anal, division of sphincter (separate procedure)
46083		162.38	Incision of thrombosed hemorrhoid, external
46200	02	292.83	Fissurectomy, with or without sphincterotomy
46210	02	312.74	Cryptectomy; single
46211	02	387.53	Cryptectomy; multiple (separate procedure)

Code	Group	Fee	40.06(8) – Surgical Services Description
46220	01	159.62	Papillectomy or excision of single tag, anus (separate procedure)
46221		149.42	Hemorrhoidectomy, by simple ligature (eg, rubber band)
46230		233.16	Excision of external hemorrhoid tags and/or multiple papillae
46250	03	366.78	Hemorrhoidectomy, external, complete
46255	03	419.31	Hemorrhoidectomy, internal and external, simple;
46257	03	347.22	Hemorrhoidectomy, internal and external, simple; with fissurectomy
46258	03	378.32	Hemorrhoidectomy, internal and external, simple; with fistulectomy, with or without fissurectomy
46260	03	401.85	Hemorrhoidectomy, internal and external, complex or extensive;
46261	04	446.08	Hemorrhoidectomy, internal and external, complex or extensive; with fissurectomy
46262	04	469.80	Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy
46270	03	349.24	Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous
46275	03	369.77	Surgical treatment of anal fistula (fistulectomy/fistulotomy); submuscular
46280	04	382.65	Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple, with or without placement of seton
46285	01	317.49	Surgical treatment of anal fistula (fistulectomy/fistulotomy); second stage
46288	04	446.90	Closure of anal fistula with rectal advancement flap
46320		155.18	Enucleation or excision of external thrombotic hemorrhoid
46500		182.52	Injection of sclerosing solution, hemorrhoids
46600		86.96	Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
46604		444.73	Anoscopy; with dilation (eg, balloon, guide wire, bougie)
46606		194.39	Anoscopy; with biopsy, single or multiple
46608	01	248.06	Anoscopy; with removal of foreign body
46610	01	225.96	Anoscopy; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
46611	01	214.87	Anoscopy; with removal of single tumor, polyp, or other lesion by snare technique
46612	01	313.62	Anoscopy; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
46614		177.01	Anoscopy; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
46615	02	215.69	Anoscopy; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
46700	03	543.04	Anoplasty, plastic operation for stricture; adult
46705	03	444.29	Anoplasty, plastic operation for stricture; infant
46706		148.70	Repair of anal fistula with fibrin glue
46715		452.16	Repair of low imperforate anus; with anoperineal fistula (cut-back procedure)
46716		951.01	Repair of low imperforate anus; with transposition of anoperineal or anovestibular fistula
46730		1,588.24	Repair of high imperforate anus without fistula; perineal or sacroperineal approach
46735		1,879.06	Repair of high imperforate anus without fistula; combined transabdominal and sacroperineal approaches
46740		1,758.62	Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach
46742		2,182.58	Repair of high imperforate anus with rectourethral or rectovaginal fistula; combined transabdominal

Code	Group	Fee	40.06(8) – Surgical Services Description
			and sacroperineal approaches
46744		2,956.25	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach
46746		3,345.25	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach;
46748		3,521.46	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach; with vaginal lengthening by intestinal graft or pedicle flaps
46750	03	625.65	Sphincteroplasty, anal, for incontinence or prolapse; adult
46751	03	590.80	Sphincteroplasty, anal, for incontinence or prolapse; child
46753	03	496.79	Graft (Thiersch operation) for rectal incontinence and/or prolapse
46754	02	238.49	Removal of Thiersch wire or suture, anal canal
46760	02	874.31	Sphincteroplasty, anal, for incontinence, adult; muscle transplant
46761	03	806.90	Sphincteroplasty, anal, for incontinence, adult; levator muscle imbrication (Park posterior anal repair)
46762	07	738.71	Sphincteroplasty, anal, for incontinence, adult; implantation artificial sphincter
46900		226.05	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
46910		188.21	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation
46916		204.96	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery
46917	01	462.39	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery
46922	01	216.39	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision
46924	01	477.60	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
46934		352.47	Destruction of hemorrhoids, any method; internal
46935		243.36	Destruction of hemorrhoids, any method; external
46936		337.15	Destruction of hemorrhoids, any method; internal and external
46937	02	220.72	Cryosurgery of rectal tumor; benign
46938	02	367.64	Cryosurgery of rectal tumor; malignant
46940		177.67	Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); initial
46942		159.59	Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); subsequent
46945		224.91	Ligation of internal hemorrhoids; single procedure
46946		281.17	Ligation of internal hemorrhoids; multiple procedures
46999		I.C.	Unlisted procedure, anus
47000	01	212.37	Biopsy of liver, needle; percutaneous
47001		105.65	Biopsy of liver, needle; when done for indicated purpose at time of other major procedure (List separately in addition to code for primary procedure)
47010		986.80	Hepatotomy; for open drainage of abscess or cyst, one or two stages
47011		196.46	Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stages
47015		918.92	Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or echinococcal) cyst(s) or abscess(es)
47100		723.45	Biopsy of liver, wedge

Code	Group	Fee	40.06(8) – Surgical Services Description
47120		2,063.71	Hepatectomy, resection of liver; partial lobectomy
47122		3,117.47	Hepatectomy, resection of liver; trisegmentectomy
47125		2,796.65	Hepatectomy, resection of liver; total left lobectomy
47130		3,025.61	Hepatectomy, resection of liver; total right lobectomy
47133		I.C.	Donor hepatectomy, with preparation and maintenance of allograft, from cadaver donor
47135		4,715.66	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age
47136		3,993.07	Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age
47140		3,173.57	Donor hepatectomy, with preparation and maintenance of allograft, from living donor; left lateral segment only (segments II and III)
47141		3,840.22	Donor hepatectomy, with preparation and maintenance of allograft, from living donor; total left lobectomy (segments II, III and IV)
47142		4,231.43	Donor hepatectomy, with preparation and maintenance of allograft, from living donor; total right lobectomy (segments V, VI, VII and VIII)
47300		910.31	Marsupialization of cyst or abscess of liver
47350		1,158.20	Management of liver hemorrhage; simple suture of liver wound or injury
47360		1,567.36	Management of liver hemorrhage; complex suture of liver wound or injury, with or without hepatic artery ligation
47361		2,672.47	Management of liver hemorrhage; exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver
47362		1,111.92	Management of liver hemorrhage; re-exploration of hepatic wound for removal of packing
47370		1,117.09	Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
47371		1,117.52	Laparoscopy, surgical, ablation of one or more liver tumor(s); cryosurgical
47379		I.C.	Unlisted laparoscopic procedure, liver
47380		1,292.92	Ablation, open, of one or more liver tumor(s); radiofrequency
47381		1,314.07	Ablation, open, of one or more liver tumor(s); cryosurgical
47382		870.29	Ablation, one or more liver tumor(s), percutaneous, radiofrequency
47399		I.C.	Unlisted procedure, liver
47400		1,860.48	Hepaticotomy or hepaticostomy with exploration, drainage, or removal of calculus
47420		1,181.82	Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; without transduodenal sphincterotomy or sphincteroplasty
47425		1,178.44	Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; with transduodenal sphincterotomy or sphincteroplasty
47460		1,079.08	Transduodenal sphincterotomy or sphincteroplasty, with or without transduodenal extraction of calculus (separate procedure)
47480		689.82	Cholecystotomy or cholecystostomy with exploration, drainage, or removal of calculus (separate procedure)
47490		530.02	Percutaneous cholecystostomy
47500		104.19	Injection procedure for percutaneous transhepatic cholangiography
47505		139.46	Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube)
47510	02	518.98	Introduction of percutaneous transhepatic catheter for biliary drainage
47511	09	626.86	Introduction of percutaneous transhepatic stent for internal and external biliary drainage
47525	01	355.03	Change of percutaneous biliary drainage catheter

Code	Group	Fee	40.06(8) – Surgical Services Description
47530	01	412.83	Revision and/or reinsertion of transhepatic tube
47550		168.10	Biliary endoscopy, intraoperative (choledochoscopy) (List separately in addition to code for primary procedure)
47552	02	343.86	Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with or without collection of specimen(s) by brushing and/or washing (separate procedure)
47553	03	359.48	Biliary endoscopy, percutaneous via T-tube or other tract; with biopsy, single or multiple
47554	03	510.45	Biliary endoscopy, percutaneous via T-tube or other tract; with removal of calculus/calculi
47555	03	424.19	Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) without stent
47556	09	476.59	Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) with stent
47560	03	278.86	Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy
47561	03	302.44	Laparoscopy, surgical; with guided transhepatic cholangiography with biopsy
47562		669.00	Laparoscopy, surgical; cholecystectomy
47563		717.54	Laparoscopy, surgical; cholecystectomy with cholangiography
47564		839.70	Laparoscopy, surgical; cholecystectomy with exploration of common duct
47570		747.03	Laparoscopy, surgical; cholecystoenterostomy
47579		I.C.	Unlisted laparoscopy procedure, biliary tract
47600		814.69	Cholecystectomy;
47605		874.60	Cholecystectomy; with cholangiography
47610		1,103.56	Cholecystectomy with exploration of common duct;
47612		1,099.64	Cholecystectomy with exploration of common duct; with choledochoenterostomy
47620		1,203.18	Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography
47630	03	562.00	Biliary duct stone extraction, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique)
47700		954.27	Exploration for congenital atresia of bile ducts, without repair, with or without liver biopsy, with or without cholangiography
47701		1,643.91	Portoenterostomy (eg, Kasai procedure)
47711		1,360.97	Excision of bile duct tumor, with or without primary repair of bile duct; extrahepatic
47712		1,761.95	Excision of bile duct tumor, with or without primary repair of bile duct; intrahepatic
47715		1,123.28	Excision of choledochal cyst
47716		1,002.35	Anastomosis, choledochal cyst, without excision
47720		966.53	Cholecystoenterostomy; direct
47721		1,142.75	Cholecystoenterostomy; with gastroenterostomy
47740		1,109.53	Cholecystoenterostomy; Roux-en-Y
47741		1,263.72	Cholecystoenterostomy; Roux-en-Y with gastroenterostomy
47760		1,513.69	Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract
47765		1,474.64	Anastomosis, of intrahepatic ducts and gastrointestinal tract
47780		1,555.47	Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract
47785		1,819.50	Anastomosis, Roux-en-Y, of intrahepatic biliary ducts and gastrointestinal tract
47800		1,375.01	Reconstruction, plastic, of extrahepatic biliary ducts with end-to-end anastomosis

Code	Group	Fee	40.06(8) – Surgical Services Description
47801		947.35	Placement of choledochal stent
47802		1,289.52	U-tube hepaticoenterostomy
47900		1,185.41	Suture of extrahepatic biliary duct for pre-existing injury (separate procedure)
47999		I.C.	Unlisted procedure, biliary tract
48000		1,592.85	Placement of drains, peripancreatic, for acute pancreatitis;
48001		1,991.67	Placement of drains, peripancreatic, for acute pancreatitis; with cholecystostomy, gastrostomy, and jejunostomy
48005		2,370.87	Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis
48020		950.31	Removal of pancreatic calculus
48100		737.59	Biopsy of pancreas, open (eg, fine needle aspiration, needle core biopsy, wedge biopsy)
48102	01	564.38	Biopsy of pancreas, percutaneous needle
48120		936.69	Excision of lesion of pancreas (eg, cyst, adenoma)
48140		1,345.39	Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy
48145		1,403.30	Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy
48146		1,591.54	Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)
48148		1,034.68	Excision of ampulla of Vater
48150		2,795.91	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy
48152		2,567.94	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); without pancreatojejunostomy
48153		2,794.65	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy
48154		2,583.61	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); without pancreatojejunostomy
48155		1,508.99	Pancreatectomy, total
48160		I.C.	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells
48180		1,442.47	Pancreaticojejunostomy, side-to-side anastomosis (Puestow-type operation)
48400		104.11	Injection procedure for intraoperative pancreatography (List separately in addition to code for primary procedure)
48500		936.28	Marsupialization of pancreatic cyst
48510		895.40	External drainage, pseudocyst of pancreas; open
48511		211.98	External drainage, pseudocyst of pancreas; percutaneous
48520		922.67	Internal anastomosis of pancreatic cyst to gastrointestinal tract; direct
48540		1,152.46	Internal anastomosis of pancreatic cyst to gastrointestinal tract; Roux-en-Y
48545		1,081.95	Pancreatorrhaphy for injury
48547		1,500.33	Duodenal exclusion with gastrojejunostomy for pancreatic injury
48550		I.C.	Donor pancreatectomy, with preparation and maintenance of allograft from cadaver donor, with or without duodenal segment for transplantation
48554		2,136.13	Transplantation of pancreatic allograft
48556		996.01	Removal of transplanted pancreatic allograft

Code	Group	Fee	40.06(8) – Surgical Services Description
48999		I.C.	Unlisted procedure, pancreas
49000		710.46	Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)
49002		646.93	Reopening of recent laparotomy
49010		757.22	Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)
49020		1,339.21	Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; open
49021		179.99	Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous
49040		812.11	Drainage of subdiaphragmatic or subphrenic abscess; open
49041		212.28	Drainage of subdiaphragmatic or subphrenic abscess; percutaneous
49060		940.53	Drainage of retroperitoneal abscess; open
49061		196.46	Drainage of retroperitoneal abscess; percutaneous
49062		698.46	Drainage of extraperitoneal lymphocele to peritoneal cavity, open
49080	02	230.35	Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial
49081	02	160.06	Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent
49085	02	723.21	Removal of peritoneal foreign body from peritoneal cavity
49180	01	208.19	Biopsy, abdominal or retroperitoneal mass, percutaneous needle
49200		633.20	Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas;
49201		911.23	Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas; extensive
49215		1,945.02	Excision of presacral or sacrococcygeal tumor
49220		896.96	Staging laparotomy for Hodgkins disease or lymphoma (includes splenectomy, needle or open biopsies of both liver lobes, possibly also removal of abdominal nodes, abdominal node and/or bone marrow biopsies, ovarian repositioning)
49250	04	527.32	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)
49255		698.41	Omentectomy, epiploectomy, resection of omentum (separate procedure)
49320	03	321.22	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
49321	04	334.16	Laparoscopy, surgical; with biopsy (single or multiple)
49322	04	361.30	Laparoscopy, surgical; with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)
49323		579.44	Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity
49329		I.C.	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum
49400		108.10	Injection of air or contrast into peritoneal cavity (separate procedure)
49419		420.26	Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (ie, totally implantable)
49420	01	135.73	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary
49421	01	363.22	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent
49422	01	380.77	Removal of permanent intraperitoneal cannula or catheter
49423		85.70	Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)
49424		48.41	Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure)
49425		709.96	Insertion of peritoneal-venous shunt

Code	Group	Fee	40.06(8) – Surgical Services Description
49426	02	599.54	Revision of peritoneal-venous shunt
49427		55.60	Injection procedure (eg, contrast media) for evaluation of previously placed peritoneal-venous shunt
49428		377.93	Ligation of peritoneal-venous shunt
49429		453.07	Removal of peritoneal-venous shunt
49491		672.56	Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; reducible
49492		840.22	Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; incarcerated or strangulated
49495	04	369.19	Repair, initial inguinal hernia, full term infant under age 6 months, or preterm infant over 50 weeks postconception age and under age 6 months at the time of surgery, with or without hydrocelectomy; reducible
49496	04	548.59	Repair, initial inguinal hernia, full term infant under age 6 months, or preterm infant over 50 weeks postconception age and under age 6 months at the time of surgery, with or without hydrocelectomy; incarcerated or strangulated
49500	04	355.55	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; reducible
49501	09	540.81	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; incarcerated or strangulated
49505	04	482.44	Repair initial inguinal hernia, age 5 years or over; reducible
49507	09	581.88	Repair initial inguinal hernia, age 5 years or over; incarcerated or strangulated
49520	07	582.33	Repair recurrent inguinal hernia, any age; reducible
49521	09	710.69	Repair recurrent inguinal hernia, any age; incarcerated or strangulated
49525	04	523.58	Repair inguinal hernia, sliding, any age
49540	02	626.50	Repair lumbar hernia
49550	05	527.41	Repair initial femoral hernia, any age; reducible
49553	09	573.60	Repair initial femoral hernia, any age; incarcerated or strangulated
49555	05	550.74	Repair recurrent femoral hernia; reducible
49557	09	666.83	Repair recurrent femoral hernia; incarcerated or strangulated
49560	04	691.46	Repair initial incisional or ventral hernia; reducible
49561	09	838.56	Repair initial incisional or ventral hernia; incarcerated or strangulated
49565	04	694.41	Repair recurrent incisional or ventral hernia; reducible
49566	09	847.77	Repair recurrent incisional or ventral hernia; incarcerated or strangulated
49568	07	272.84	Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair)
49570	04	367.08	Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)
49572	09	421.94	Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated
49580	04	278.19	Repair umbilical hernia, under age 5 years; reducible
49582	09	419.89	Repair umbilical hernia, under age 5 years; incarcerated or strangulated
49585	04	394.97	Repair umbilical hernia, age 5 years or over; reducible
49587	09	467.44	Repair umbilical hernia, age 5 years or over; incarcerated or strangulated
49590	03	522.45	Repair spigelian hernia
49600	04	680.54	Repair of small omphalocele, with primary closure
49605		4,162.52	Repair of large omphalocele or gastroschisis; with or without prosthesis
49606		1,108.18	Repair of large omphalocele or gastroschisis; with removal of prosthesis, final reduction and closure,

Code	Group	Fee	40.06(8) – Surgical Services Description
			in operating room
49610		644.82	Repair of omphalocele (Gross type operation); first stage
49611		665.00	Repair of omphalocele (Gross type operation); second stage
49650	04	395.31	Laparoscopy, surgical; repair initial inguinal hernia
49651	07	513.05	Laparoscopy, surgical; repair recurrent inguinal hernia
49659		I.C.	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy
49900		771.43	Suture, secondary, of abdominal wall for evisceration or dehiscence
49904		1,476.27	Omental flap, extra-abdominal (eg, for reconstruction of sternal and chest wall defects)
49905		365.77	Omental flap, intra-abdominal (List separately in addition to code for primary procedure)
49906		I.C.	Free omental flap with microvascular anastomosis
49999		I.C.	Unlisted procedure, abdomen, peritoneum and omentum
50010		670.27	Renal exploration, not necessitating other specific procedures
50020		952.24	Drainage of perirenal or renal abscess; open
50021		179.27	Drainage of perirenal or renal abscess; percutaneous
50040		947.26	Nephrostomy, nephrotomy with drainage
50045		907.28	Nephrotomy, with exploration
50060		1,106.26	Nephrolithotomy; removal of calculus
50065		1,086.69	Nephrolithotomy; secondary surgical operation for calculus
50070		1,163.56	Nephrolithotomy; complicated by congenital kidney abnormality
50075		1,438.20	Nephrolithotomy; removal of large staghorn calculus filling renal pelvis and calyces (including anatrophic pyelolithotomy)
50080		916.06	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm
50081		1,304.33	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm
50100		1,002.19	Transection or repositioning of aberrant renal vessels (separate procedure)
50120		930.51	Pyelotomy; with exploration
50125		961.04	Pyelotomy; with drainage, pyelostomy
50130		999.46	Pyelotomy; with removal of calculus (pyelolithotomy, pelviolithotomy, including coagulum pyelolithotomy)
50135		1,101.12	Pyelotomy; complicated (eg, secondary operation, congenital kidney abnormality)
50200	01	141.32	Renal biopsy; percutaneous, by trocar or needle
50205		680.52	Renal biopsy; by surgical exposure of kidney
50220		1,001.21	Nephrectomy, including partial ureterectomy, any open approach including rib resection;
50225		1,159.74	Nephrectomy, including partial ureterectomy, any open approach including rib resection; complicated because of previous surgery on same kidney
50230		1,252.24	Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy
50234		1,274.13	Nephrectomy with total ureterectomy and bladder cuff; through same incision
50236		1,471.22	Nephrectomy with total ureterectomy and bladder cuff; through separate incision
50240		1,320.29	Nephrectomy, partial

Code	Group	Fee	40.06(8) – Surgical Services Description
50280		916.29	Excision or unroofing of cyst(s) of kidney
50290		875.22	Excision of perinephric cyst
50300		I.C.	Donor nephrectomy, with preparation and maintenance of allograft, from cadaver donor, unilateral or bilateral
50320		1,320.74	Donor nephrectomy, open from living donor (excluding preparation and maintenance of allograft)
50340		791.23	Recipient nephrectomy (separate procedure)
50360		1,958.82	Renal allotransplantation, implantation of graft; excluding donor and recipient nephrectomy
50365		2,294.65	Renal allotransplantation, implantation of graft; with recipient nephrectomy
50370		879.21	Removal of transplanted renal allograft
50380		1,405.77	Renal autotransplantation, reimplantation of kidney
50390	01	104.19	Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous
50392	01	179.27	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous
50393	01	220.00	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous
50394		137.23	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter
50395	01	179.15	Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous
50396	01	118.67	Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter
50398	01	107.62	Change of nephrostomy or pyelostomy tube
50400		1,103.43	Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple
50405		1,392.20	Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidney, calycoplasty)
50500		1,159.03	Nephrorrhaphy, suture of kidney wound or injury
50520		1,063.04	Closure of nephrocutaneous or pyelocutaneous fistula
50525		1,321.54	Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; abdominal approach
50526		1,421.40	Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; thoracic approach
50540		1,157.03	Symphysiotomy for horseshoe kidney with or without pyeloplasty and/or other plastic procedure, unilateral or bilateral (one operation)
50541		908.50	Laparoscopy, surgical; ablation of renal cysts
50542		1,144.97	Laparoscopy, surgical; ablation of renal mass lesion(s)
50543		1,442.21	Laparoscopy, surgical; partial nephrectomy
50544		1,251.60	Laparoscopy, surgical; pyeloplasty
50545		1,343.46	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)
50546		1,170.53	Laparoscopy, surgical; nephrectomy, including partial ureterectomy
50547		1,473.96	Laparoscopy, surgical; donor nephrectomy from living donor (excluding preparation and maintenance of allograft)
50548		1,356.62	Laparoscopy, surgical; nephrectomy with total ureterectomy
50549		I.C.	Unlisted laparoscopy procedure, renal
50551	01	430.19	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation,

Code	Group	Fee	40.06(8) – Surgical Services Description
			instillation, or ureteropyelography, exclusive of radiologic service;
50553	01	1,021.74	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
50555	01	1,067.76	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50557	01	1,108.12	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
50559	01	357.51	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance with or without biopsy and/or fulguration
50561	01	1,047.44	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50562		603.20	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with resection of tumor
50570		508.76	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50572		553.01	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
50574		588.69	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50575		745.57	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent)
50576		585.63	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
50578		604.99	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration
50580		631.87	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50590	09	815.90	Lithotripsy, extracorporeal shock wave
50600		926.92	Ureterotomy with exploration or drainage (separate procedure)
50605		918.11	Ureterotomy for insertion of indwelling stent, all types
50610		943.77	Ureterolithotomy; upper one-third of ureter
50620		882.98	Ureterolithotomy; middle one-third of ureter
50630		871.85	Ureterolithotomy; lower one-third of ureter
50650		1,010.24	Ureterectomy, with bladder cuff (separate procedure)
50660		1,126.64	Ureterectomy, total, ectopic ureter, combination abdominal, vaginal and/or perineal approach
50684		678.49	Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter
50686		252.46	Manometric studies through ureterostomy or indwelling ureteral catheter

Code	Group	Fee	40.06(8) – Surgical Services Description
50688	01	119.99	Change of ureterostomy tube
50690		713.56	Injection procedure for visualization of ileal conduit and/or ureteropyelography, exclusive of radiologic service
50700		911.73	Ureteroplasty, plastic operation on ureter (eg, stricture)
50715		1,153.12	Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis
50722		1,005.28	Ureterolysis for ovarian vein syndrome
50725		1,098.61	Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava
50727		545.89	Revision of urinary-cutaneous anastomosis (any type urostomy);
50728		767.58	Revision of urinary-cutaneous anastomosis (any type urostomy); with repair of fascial defect and hernia
50740		1,083.01	Ureteropyelostomy, anastomosis of ureter and renal pelvis
50750		1,128.19	Ureterocalycostomy, anastomosis of ureter to renal calyx
50760		1,073.90	Ureteroureterostomy
50770		1,127.65	Transureteroureterostomy, anastomosis of ureter to contralateral ureter
50780		1,066.04	Ureteroneocystostomy; anastomosis of single ureter to bladder
50782		1,190.89	Ureteroneocystostomy; anastomosis of duplicated ureter to bladder
50783		1,216.83	Ureteroneocystostomy; with extensive ureteral tailoring
50785		1,181.45	Ureteroneocystostomy; with vesico-psoas hitch or bladder flap
50800		874.74	Ureteroenterostomy, direct anastomosis of ureter to intestine
50810		1,222.84	Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or perineal colostomy, including intestine anastomosis
50815		1,174.25	Ureterocolon conduit, including intestine anastomosis
50820		1,259.41	Ureteroileal conduit (ileal bladder), including intestine anastomosis (Bricker operation)
50825		1,617.64	Continent diversion, including intestine anastomosis using any segment of small and/or large intestine (Kock pouch or Camey enterocystoplasty)
50830		1,790.83	Urinary undiversion (eg, taking down of ureteroileal conduit, ureterosigmoidostomy or ureteroenterostomy with ureteroureterostomy or ureteroneocystostomy)
50840		1,175.09	Replacement of all or part of ureter by intestine segment, including intestine anastomosis
50845		1,206.12	Cutaneous appendico-vesicostomy
50860		905.50	Ureterostomy, transplantation of ureter to skin
50900		816.34	Ureterorrhaphy, suture of ureter (separate procedure)
50920		856.15	Closure of ureterocutaneous fistula
50930		1,106.72	Closure of ureterovisceral fistula (including visceral repair)
50940		863.39	Deligation of ureter
50945		975.02	Laparoscopy, surgical; ureterolithotomy
50947	09	1,401.57	Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement
50948	09	1,276.99	Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement
50949		I.C.	Unlisted laparoscopy procedure, ureter
50951	01	457.55	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50953	01	1,032.91	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or

Code	Group	Fee	40.06(8) – Surgical Services Description
			ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
50955	01	1,132.54	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50957	01	1,039.80	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
50959	01	229.90	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration (not including provision of material)
50961	01	1,314.03	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50970	01	381.42	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
50972	01	369.23	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
50974	01	488.13	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50976	01	482.38	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
50978	01	273.14	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration (not including provision of material)
50980	01	365.37	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
51000		114.68	Aspiration of bladder by needle
51005		243.80	Aspiration of bladder; by trocar or intracatheter
51010	01	383.10	Aspiration of bladder; with insertion of suprapubic catheter
51020	04	435.73	Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material
51030	04	442.63	Cystotomy or cystostomy; with cryosurgical destruction of intravesical lesion
51040	04	296.43	Cystostomy, cystotomy with drainage
51045	04	443.16	Cystotomy, with insertion of ureteral catheter or stent (separate procedure)
51050	04	433.95	Cystolithotomy, cystotomy with removal of calculus, without vesical neck resection
51060		547.60	Transvesical ureterolithotomy
51065	04	540.98	Cystotomy, with calculus basket extraction and/or ultrasonic or electrohydraulic fragmentation of ureteral calculus
51080	01	391.25	Drainage of perivesical or prevesical space abscess
51500	04	627.56	Excision of urachal cyst or sinus, with or without umbilical hernia repair
51520	04	572.86	Cystotomy; for simple excision of vesical neck (separate procedure)
51525		820.41	Cystotomy; for excision of bladder diverticulum, single or multiple (separate procedure)
51530		743.23	Cystotomy; for excision of bladder tumor
51535		768.57	Cystotomy for excision, incision, or repair of ureterocele
51550		917.05	Cystectomy, partial; simple
51555		1,220.31	Cystectomy, partial; complicated (eg, postradiation, previous surgery, difficult location)

Code	Group	Fee	40.06(8) – Surgical Services Description
51565		1,249.29	Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)
51570		1,389.18	Cystectomy, complete; (separate procedure)
51575		1,731.27	Cystectomy, complete; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
51580		1,776.94	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations;
51585		1,992.72	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
51590		1,843.56	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis;
51595		2,084.30	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
51596		2,226.54	Cystectomy, complete, with continent diversion, any open technique, using any segment of small and/or large intestine to construct neobladder
51597		2,169.15	Pelvic exenteration, complete, for vesical, prostatic or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
51600		281.29	Injection procedure for cystography or voiding urethrocystography
51605		480.90	Injection procedure and placement of chain for contrast and/or chain urethrocystography
51610		113.90	Injection procedure for retrograde urethrocystography
51700		104.54	Bladder irrigation, simple, lavage and/or instillation
51701		89.19	Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)
51702		118.69	Insertion of temporary indwelling bladder catheter; simple (eg, Foley)
51703		187.30	Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)
51705		139.20	Change of cystostomy tube; simple
51710	01	204.08	Change of cystostomy tube; complicated
51715	03	318.39	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck
51720		153.57	Bladder instillation of anticarcinogenic agent (including detention time)

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
51725		304.97	81.20	223.77	Simple cystometrogram (CMG) (eg, spinal manometer)
51726	01	400.37	91.99	308.38	Complex cystometrogram (eg, calibrated electronic equipment)
51736		49.25	32.93	16.32	Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)
51741		79.72	60.99	18.73	Complex uroflowmetry (eg, calibrated electronic equipment)
51772	01	310.06	88.10	221.96	Urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique
51784		235.74	82.37	153.37	Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique
51785	01	256.94	82.07	174.87	Needle electromyography studies (EMG) of anal or urethral sphincter, any technique
51792		300.76	62.06	238.70	Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)
51795		385.50	82.37	303.13	Voiding pressure studies (VP); bladder voiding pressure, any technique
51797		316.25	85.86	230.39	Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric,

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					intraperitoneal)
51798		17.57			Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging
51800		1,022.23			Cystoplasty or cystourethroplasty, plastic operation on bladder and/or vesical neck (anterior Y-plasty, vesical fundus resection), any procedure, with or without wedge resection of posterior vesical neck
51820		1,082.61			Cystourethroplasty with unilateral or bilateral ureteroneocystostomy
51840		669.41			Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); simple
51841		796.62			Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); complicated (eg, secondary repair)
51845		594.32			Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)
51860		733.32			Cystorrhaphy, suture of bladder wound, injury or rupture; simple
51865		890.91			Cystorrhaphy, suture of bladder wound, injury or rupture; complicated
51880	01	479.54			Closure of cystostomy (separate procedure)
51900		782.03			Closure of vesicovaginal fistula, abdominal approach
51920		718.18			Closure of vesicouterine fistula;
51925		1,003.81			Closure of vesicouterine fistula; with hysterectomy
51940		1,662.99			Closure, exstrophy of bladder
51960		1,333.62			Enterocystoplasty, including intestinal anastomosis
51980		685.75			Cutaneous vesicostomy
51990		768.02			Laparoscopy, surgical; urethral suspension for stress incontinence
51992		824.19			Laparoscopy, surgical; sling operation for stress incontinence (eg, fascia or synthetic)
52000	01	222.48			Cystourethroscopy (separate procedure)
52001	02	435.20			Cystourethroscopy with irrigation and evacuation of multiple obstructing clots
52005	02	346.85			Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
52007	02	168.96			Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis
52010	02	168.12			Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service
52204	02	247.79			Cystourethroscopy, with biopsy
52214	02	203.69			Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
52224	02	173.48			Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy
52234	02	252.83			Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 cm)
52235	03	296.93			Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52240	03	526.27			Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					resection of; LARGE bladder tumor(s)
52250	04	249.19			Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration
52260	02	216.12			Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
52265		275.54			Cystourethroscopy, with dilation of bladder for interstitial cystitis; local anesthesia
52270	02	186.60			Cystourethroscopy, with internal urethrotomy; female
52275	02	257.45			Cystourethroscopy, with internal urethrotomy; male
52276	03	274.43			Cystourethroscopy with direct vision internal urethrotomy
52277	02	341.36			Cystourethroscopy, with resection of external sphincter (sphincterotomy)
52281	02	425.09			Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
52282	09	349.19			Cystourethroscopy, with insertion of urethral stent
52283	02	318.64			Cystourethroscopy, with steroid injection into stricture
52285	02	316.68			Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone
52290	02	252.58			Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral
52300	02	292.07			Cystourethroscopy; with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral
52301		305.81			Cystourethroscopy; with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral
52305	02	289.37			Cystourethroscopy; with incision or resection of orifice of bladder diverticulum, single or multiple
52310	02	261.07			Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple
52315	02	284.75			Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated
52317	01	363.54			Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)
52318	02	496.35			Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)
52320	05	256.19			Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus
52325	04	334.36			Cystourethroscopy (including ureteral catheterization); with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)
52327	02	284.18			Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material
52330	02	274.67			Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus
52332	02	157.70			Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
52334	03	266.15			Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					percutaneous nephrostomy, retrograde
52341	03	332.96			Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)
52342	03	358.20			Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)
52343	03	396.21			Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)
52344	03	425.12			Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)
52345	03	451.62			Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)
52346	03	507.07			Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)
52347		282.81			Cystourethroscopy with transurethral resection or incision of ejaculatory ducts
52351	03	323.71			Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic
52352	04	380.17			Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)
52353	04	438.43			Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)
52354	04	405.16			Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion
52355	04	484.80			Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor
52400	03	545.59			Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds
52450	03	460.61			Transurethral incision of prostate
52500	03	503.95			Transurethral resection of bladder neck (separate procedure)
52510	03	399.79			Transurethral balloon dilation of the prostatic urethra
52601	04	709.50			Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52606	01	474.81			Transurethral fulguration for postoperative bleeding occurring after the usual follow-up time
52612	02	476.86			Transurethral resection of prostate; first stage of two-stage resection (partial resection)
52614	01	414.74			Transurethral resection of prostate; second stage of two-stage resection (resection completed)
52620	01	389.87			Transurethral resection; of residual obstructive tissue after 90 days postoperative
52630	02	424.73			Transurethral resection; of regrowth of obstructive tissue longer than one year postoperative
52640	02	388.98			Transurethral resection; of postoperative bladder neck contracture
52647	09	3,645.74			Non-contact laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52648	09	649.99			Contact laser vaporization with or without transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy,

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52700	02	406.06			Transurethral drainage of prostatic abscess
53000	01	156.96			Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra
53010	01	271.39			Urethrotomy or urethrostomy, external (separate procedure); perineal urethra, external
53020	01	201.32			Meatotomy, cutting of meatus (separate procedure); except infant
53025		208.15			Meatotomy, cutting of meatus (separate procedure); infant
53040	02	731.16			Drainage of deep periurethral abscess
53060		168.70			Drainage of Skene's gland abscess or cyst
53080	03	512.20			Drainage of perineal urinary extravasation; uncomplicated (separate procedure)
53085		732.46			Drainage of perineal urinary extravasation; complicated
53200	01	284.81			Biopsy of urethra
53210	05	754.73			Urethrectomy, total, including cystostomy; female
53215	05	905.74			Urethrectomy, total, including cystostomy; male
53220	02	441.36			Excision or fulguration of carcinoma of urethra
53230	02	586.50			Excision of urethral diverticulum (separate procedure); female
53235	03	614.83			Excision of urethral diverticulum (separate procedure); male
53240	02	411.59			Marsupialization of urethral diverticulum, male or female
53250	02	376.81			Excision of bulbourethral gland (Cowper's gland)
53260	02	259.04			Excision or fulguration; urethral polyp(s), distal urethra
53265	02	202.42			Excision or fulguration; urethral caruncle
53270	02	202.85			Excision or fulguration; Skene's glands
53275	02	276.76			Excision or fulguration; urethral prolapse
53400	03	768.83			Urethroplasty; first stage, for fistula, diverticulum, or stricture (eg, Johannsen type)
53405	02	850.17			Urethroplasty; second stage (formation of urethra), including urinary diversion
53410	02	958.40			Urethroplasty, one-stage reconstruction of male anterior urethra
53415		1,087.70			Urethroplasty, transpubic or perineal, one stage, for reconstruction or repair of prostatic or membranous urethra
53420	03	834.79			Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	02	934.13			Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	02	952.58			Urethroplasty, reconstruction of female urethra
53431	02	1,140.41			Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (eg, Tenago, Leadbetter procedure)
53440	02	793.86			Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)
53442	01	687.62			Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)
53444	02	785.48			Insertion of tandem cuff (dual cuff)

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
53445	01	865.78			Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff
53446	01	631.46			Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
53447	01	809.60			Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff at the same operative session
53448		1,231.69			Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue
53449	01	590.55			Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
53450	01	387.98			Urethromeatoplasty, with mucosal advancement
53460	01	444.74			Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
53500		747.31			Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring)
53502	02	478.60			Urethrorrhaphy, suture of urethral wound or injury, female
53505	02	472.04			Urethrorrhaphy, suture of urethral wound or injury; penile
53510	02	625.08			Urethrorrhaphy, suture of urethral wound or injury; perineal
53515	02	786.19			Urethrorrhaphy, suture of urethral wound or injury; prostatomembranous
53520	02	540.05			Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure)
53600		97.35			Dilation of urethral stricture by passage of sound or urethral dilator, male; initial
53601		93.86			Dilation of urethral stricture by passage of sound or urethral dilator, male; subsequent
53605	02	68.55			Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia
53620		150.68			Dilation of urethral stricture by passage of filiform and follower, male; initial
53621		143.70			Dilation of urethral stricture by passage of filiform and follower, male; subsequent
53660		84.76			Dilation of female urethra including suppository and/or instillation; initial
53661		85.14			Dilation of female urethra including suppository and/or instillation; subsequent
53665	01	41.42			Dilation of female urethra, general or conduction (spinal) anesthesia
53850	09	4,500.72			Transurethral destruction of prostate tissue; by microwave thermotherapy
53852		4,315.19			Transurethral destruction of prostate tissue; by radiofrequency thermotherapy
53853		2,646.99			Transurethral destruction of prostate tissue; by water-induced thermotherapy
53899		I.C.			Unlisted procedure, urinary system
54000	02	117.74			Slitting of prepuce, dorsal or lateral (separate procedure); newborn
54001	02	268.95			Slitting of prepuce, dorsal or lateral (separate procedure); except newborn
54015	04	321.42			Incision and drainage of penis, deep
54050		120.40			Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
54055		115.85			Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation
54056		153.40			Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum,

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					herpetic vesicle), simple; cryosurgery
54057	01	86.43			Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery
54060	01	240.54			Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision
54065	01	168.56			Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
54100	01	196.23			Biopsy of penis; (separate procedure)
54105	01	221.73			Biopsy of penis; deep structures
54110	02	640.59			Excision of penile plaque (Peyronie disease);
54111	02	821.47			Excision of penile plaque (Peyronie disease); with graft to 5 cm in length
54112	02	955.38			Excision of penile plaque (Peyronie disease); with graft greater than 5 cm in length
54115	01	605.21			Removal foreign body from deep penile tissue (eg, plastic implant)
54120	02	633.25			Amputation of penis; partial
54125		823.39			Amputation of penis; complete
54130		1,185.14			Amputation of penis, radical; with bilateral inguinofemoral lymphadenectomy
54135		1,517.72			Amputation of penis, radical; in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
54150	01	115.44			Circumcision, using clamp or other device; newborn
54152	01	143.39			Circumcision, using clamp or other device; except newborn
54160	02	146.01			Circumcision, surgical excision other than clamp, device or dorsal slit; newborn
54161	02	196.69			Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn
54162	02	204.64			Lysis or excision of penile post-circumcision adhesions
54163	02	205.06			Repair incomplete circumcision
54164	02	177.96			Frenulotomy of penis
54200		120.06			Injection procedure for Peyronie disease;
54205	04	519.36			Injection procedure for Peyronie disease; with surgical exposure of plaque
54220	01	262.74			Irrigation of corpora cavernosa for priapism
54230		100.74			Injection procedure for corpora cavernosography
54231		141.04			Dynamic cavernosometry, including intracavernosal injection of vasoactive drugs (eg, papaverine, phentolamine)
54235		88.59			Injection of corpora cavernosa with pharmacologic agent(s) (eg, papaverine, phentolamine)
54240		96.77	70.10	26.67	Penile plethysmography
54250		128.61	118.74	9.87	Nocturnal penile tumescence and/or rigidity test
54300	03	657.29			Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra
54304	03	772.62			Plastic operation on penis for correction of chordee or for first stage hypospadias repair with or without transplantation of prepuce and/or skin flaps

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
54308	03	730.64			Urethroplasty for second stage hypospadias repair (including urinary diversion); less than 3 cm
54312	03	843.87			Urethroplasty for second stage hypospadias repair (including urinary diversion); greater than 3 cm
54316	03	1,013.00			Urethroplasty for second stage hypospadias repair (including urinary diversion) with free skin graft obtained from site other than genitalia
54318	03	718.09			Urethroplasty for third stage hypospadias repair to release penis from scrotum (eg, third stage Cecil repair)
54322	03	797.23			One stage distal hypospadias repair (with or without chordee or circumcision); with simple meatal advancement (eg, Magpi, V-flap)
54324	03	997.99			One stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps (eg, flip-flap, prepucial flap)
54326	03	962.87			One stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps and mobilization of urethra
54328	03	936.75			One stage distal hypospadias repair (with or without chordee or circumcision); with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap
54332		1,013.83			One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap
54336		1,274.72			One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap
54340	03	583.02			Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple
54344	03	976.20			Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring mobilization of skin flaps and urethroplasty with flap or patch graft
54348	03	1,045.01			Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion)
54352	03	1,474.69			Repair of hypospadias cripple requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as flaps or grafts
54360	03	736.15			Plastic operation on penis to correct angulation
54380	03	826.16			Plastic operation on penis for epispadias distal to external sphincter;
54385	03	963.29			Plastic operation on penis for epispadias distal to external sphincter; with incontinence
54390		1,265.07			Plastic operation on penis for epispadias distal to external sphincter; with exstrophy of bladder
54400	03	546.26			Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	03	654.86			Insertion of penile prosthesis; inflatable (self-contained)
54405	03	789.94			Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406	03	712.69			Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	03	751.77			Repair of component(s) of a multi-component, inflatable penile prosthesis

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
54410	03	899.29			Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411		930.27			Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	03	506.23			Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	03	657.00			Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417		815.93			Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54420	04	696.69			Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral
54430		624.91			Corpora cavernosa-corpus spongiosum shunt (priapism operation), unilateral or bilateral
54435	04	400.54			Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism
54440	04	I.C.			Plastic operation of penis for injury
54450	01	91.43			Foreskin manipulation including lysis of preputial adhesions and stretching
54500	01	78.11			Biopsy of testis, needle (separate procedure)
54505	01	218.95			Biopsy of testis, incisional (separate procedure)
54512	02	518.51			Excision of extraparenchymal lesion of testis
54520	03	328.98			Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54522	03	587.34			Orchiectomy, partial
54530	04	524.05			Orchiectomy, radical, for tumor; inguinal approach
54535		726.38			Orchiectomy, radical, for tumor; with abdominal exploration
54550	04	475.10			Exploration for undescended testis (inguinal or scrotal area)
54560		670.02			Exploration for undescended testis with abdominal exploration
54600	04	432.34			Reduction of torsion of testis, surgical, with or without fixation of contralateral testis
54620	03	299.62			Fixation of contralateral testis (separate procedure)
54640	04	437.70			Orchiopexy, inguinal approach, with or without hernia repair
54650		693.11			Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens)
54660	02	333.49			Insertion of testicular prosthesis (separate procedure)
54670	03	408.22			Suture or repair of testicular injury
54680	03	775.31			Transplantation of testis(es) to thigh (because of scrotal destruction)
54690	09	661.53			Laparoscopy, surgical; orchiectomy
54692		746.18			Laparoscopy, surgical; orchiopexy for intra-abdominal testis
54699		I.C.			Unlisted laparoscopy procedure, testis
54700	02	219.57			Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
54800	01	133.01			Biopsy of epididymis, needle
54820	01	331.91			Exploration of epididymis, with or without biopsy
54830	03	344.63			Excision of local lesion of epididymis
54840	04	326.53			Excision of spermatocele, with or without epididymectomy
54860	03	393.81			Epididymectomy; unilateral
54861	04	538.77			Epididymectomy; bilateral
54900	04	792.62			Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral
54901	04	1,060.34			Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral
55000		146.47			Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication
55040	03	339.12			Excision of hydrocele; unilateral
55041	05	479.80			Excision of hydrocele; bilateral
55060	04	353.22			Repair of tunica vaginalis hydrocele (Bottle type)
55100	01	244.64			Drainage of scrotal wall abscess
55110	02	361.52			Scrotal exploration
55120	02	446.37			Removal of foreign body in scrotum
55150	01	455.91			Resection of scrotum
55175	01	338.21			Scrotoplasty; simple
55180	02	659.75			Scrotoplasty; complicated
55200	02	401.62			Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)
55250	02	513.90			Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
55300		194.41			Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral
55400	01	513.56			Vasovasostomy, vasovasorrhaphy
55450		467.62			Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)
55500	03	358.80			Excision of hydrocele of spermatic cord, unilateral (separate procedure)
55520	04	386.94			Excision of lesion of spermatic cord (separate procedure)
55530	04	355.37			Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure)
55535	04	407.73			Excision of varicocele or ligation of spermatic veins for varicocele; abdominal approach
55540	05	478.26			Excision of varicocele or ligation of spermatic veins for varicocele; with hernia repair
55550	09	404.42			Laparoscopy, surgical, with ligation of spermatic veins for varicocele
55559		I.C.			Unlisted laparoscopy procedure, spermatic cord
55600		396.91			Vesiculotomy;
55605		503.08			Vesiculotomy; complicated
55650		695.84			Vesiculectomy, any approach

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
55680	01	334.16			Excision of Mullerian duct cyst
55700	02	245.33			Biopsy, prostate; needle or punch, single or multiple, any approach
55705	02	279.05			Biopsy, prostate; incisional, any approach
55720	01	470.13			Prostatotomy, external drainage of prostatic abscess, any approach; simple
55725	02	540.29			Prostatotomy, external drainage of prostatic abscess, any approach; complicated
55801		1,020.19			Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)
55810		1,266.41			Prostatectomy, perineal radical;
55812		1,566.67			Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55815		1,722.14			Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
55821		833.92			Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, one or two stages
55831		907.55			Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal
55840		1,301.93			Prostatectomy, retropubic radical, with or without nerve sparing;
55842		1,393.51			Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55845		1,605.23			Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
55859	09	747.20			Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
55860		845.32			Exposure of prostate, any approach, for insertion of radioactive substance;
55862		1,068.99			Exposure of prostate, any approach, for insertion of radioactive substance; with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55865		1,306.19			Exposure of prostate, any approach, for insertion of radioactive substance; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
55866		1,704.65			Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing
55870		167.31			Electroejaculation
55873		1,150.20			Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)
55899		I.C.			Unlisted procedure, male genital system
55970		I.C.			Intersex surgery; male to female
55980		I.C.			Intersex surgery; female to male
56405	02	115.47			Incision and drainage of vulva or perineal abscess
56420		153.75			Incision and drainage of Bartholin's gland abscess
56440	02	189.38			Marsupialization of Bartholin's gland cyst
56441	01	157.73			Lysis of labial adhesions
56501	01	138.55			Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
56515	03	218.17			Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
56605	01	91.33			Biopsy of vulva or perineum (separate procedure); one lesion
56606		43.50			Biopsy of vulva or perineum (separate procedure); each separate additional lesion (List separately in addition to code for primary procedure)
56620	05	512.93			Vulvectomy simple; partial
56625	07	573.88			Vulvectomy simple; complete
56630		803.12			Vulvectomy, radical, partial;
56631		1,046.92			Vulvectomy, radical, partial; with unilateral inguinofemoral lymphadenectomy
56632		1,243.00			Vulvectomy, radical, partial; with bilateral inguinofemoral lymphadenectomy
56633		1,047.05			Vulvectomy, radical, complete;
56634		1,141.85			Vulvectomy, radical, complete; with unilateral inguinofemoral lymphadenectomy
56637		1,379.62			Vulvectomy, radical, complete; with bilateral inguinofemoral lymphadenectomy
56640		1,372.03			Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy
56700	01	176.65			Partial hymenectomy or revision of hymenal ring
56720	01	44.48			Hymenotomy, simple incision
56740	03	289.57			Excision of Bartholin's gland or cyst
56800	03	252.13			Plastic repair of introitus
56805		1,173.57			Clitoroplasty for intersex state
56810	05	267.01			Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
56820		116.65			Colposcopy of the vulva;
56821		157.14			Colposcopy of the vulva; with biopsy(s)
57000	01	195.12			Colpotomy; with exploration
57010	02	410.00			Colpotomy; with drainage of pelvic abscess
57020	02	102.01			Colpocentesis (separate procedure)
57022		168.47			Incision and drainage of vaginal hematoma; obstetrical/postpartum
57023	01	296.62			Incision and drainage of vaginal hematoma; non-obstetrical (eg, post-trauma, spontaneous bleeding)
57061		121.91			Destruction of vaginal lesion(s); simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
57065	01	204.67			Destruction of vaginal lesion(s); extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
57100		95.22			Biopsy of vaginal mucosa; simple (separate procedure)
57105	02	151.38			Biopsy of vaginal mucosa; extensive, requiring suture (including cysts)
57106		437.50			Vaginectomy, partial removal of vaginal wall;
57107		1,387.39			Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57109		1,566.06			Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
57110		897.85			Vaginectomy, complete removal of vaginal wall;
57111		1,647.55			Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57112		1,685.11			Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)
57120		501.64			Colpocleisis (Le Fort type)
57130	02	191.51			Excision of vaginal septum
57135	02	205.67			Excision of vaginal cyst or tumor
57150		69.63			Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease
57155		433.14			Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy
57160		82.81			Fitting and insertion of pessary or other intravaginal support device
57170		100.42			Diaphragm or cervical cap fitting with instructions
57180	01	157.18			Introduction of any hemostatic agent or pack for spontaneous or traumatic nonobstetrical vaginal hemorrhage (separate procedure)
57200	01	284.66			Colporrhaphy, suture of injury of vagina (nonobstetrical)
57210	02	357.59			Colpoperineorrhaphy, suture of injury of vagina and/or perineum (nonobstetrical)
57220	03	308.97			Plastic operation on urethral sphincter, vaginal approach (eg, Kelly urethral plication)
57230	03	374.47			Plastic repair of urethrocele
57240	05	409.59			Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele
57250	05	378.98			Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy
57260	05	546.34			Combined anteroposterior colporrhaphy;
57265	07	723.41			Combined anteroposterior colporrhaphy; with enterocele repair
57268	03	456.00			Repair of enterocele, vaginal approach (separate procedure)
57270		762.92			Repair of enterocele, abdominal approach (separate procedure)
57280		930.10			Colpopexy, abdominal approach
57282		589.18			Sacrospinous ligament fixation for prolapse of vagina
57284	01	822.69			Paravaginal defect repair (including repair of cystocele, stress urinary incontinence, and/or incomplete vaginal prolapse)
57287		662.50			Removal or revision of sling for stress incontinence (eg, fascia or synthetic)
57288	01	772.24			Sling operation for stress incontinence (eg, fascia or synthetic)
57289	05	726.29			Pereyra procedure, including anterior colporrhaphy
57291	05	536.69			Construction of artificial vagina; without graft
57292		833.89			Construction of artificial vagina; with graft
57300	03	493.05			Closure of rectovaginal fistula; vaginal or transanal approach
57305		832.06			Closure of rectovaginal fistula; abdominal approach
57307		955.57			Closure of rectovaginal fistula; abdominal approach, with concomitant colostomy
57308		624.54			Closure of rectovaginal fistula; transperineal approach, with perineal body reconstruction, with or without levator plication

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
57310		435.89			Closure of urethrovaginal fistula;
57311		495.35			Closure of urethrovaginal fistula; with bulbocavernosus transplant
57320		510.02			Closure of vesicovaginal fistula; vaginal approach
57330		739.80			Closure of vesicovaginal fistula; transvesical and vaginal approach
57335		1,148.76			Vaginoplasty for intersex state
57400	02	141.33			Dilation of vagina under anesthesia
57410	02	156.24			Pelvic examination under anesthesia
57415	02	149.01			Removal of impacted vaginal foreign body (separate procedure) under anesthesia
57420		122.11			Colposcopy of the entire vagina, with cervix if present;
57421		166.59			Colposcopy of the entire vagina, with cervix if present; with biopsy(s)
57425		927.37			Laparoscopy, surgical, colpopexy (suspension of vaginal apex)
57452		119.18			Colposcopy of the cervix including upper/adjacent vagina;
57454		166.85			Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage
57455		153.61			Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix
57456		145.38			Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage
57460	01	371.10			Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix
57461		405.11			Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix
57500		152.31			Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)
57505		109.15			Endocervical curettage (not done as part of a dilation and curettage)
57510		144.43			Cautery of cervix; electro or thermal
57511		155.81			Cautery of cervix; cryocautery, initial or repeat
57513	02	157.37			Cautery of cervix; laser ablation
57520	02	372.38			Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser
57522	02	321.99			Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision
57530	03	342.23			Trachelectomy (cervicectomy), amputation of cervix (separate procedure)
57531		1,701.14			Radical trachelectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling biopsy, with or without removal of tube(s), with or without removal of ovary(s)
57540		768.15			Excision of cervical stump, abdominal approach;
57545		820.12			Excision of cervical stump, abdominal approach; with pelvic floor repair
57550	03	390.67			Excision of cervical stump, vaginal approach;
57555	01	585.89			Excision of cervical stump, vaginal approach; with anterior and/or posterior repair
57556	05	549.76			Excision of cervical stump, vaginal approach; with repair of enterocele

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
57700	01	276.17			Cerclage of uterine cervix, nonobstetrical
57720	03	302.84			Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach
57800	01	64.07			Dilation of cervical canal, instrumental (separate procedure)
57820	03	132.08			Dilation and curettage of cervical stump
58100		116.16			Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
58120	02	232.68			Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
58140		903.15			Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 grams or less and/or removal of surface myomas; abdominal approach
58145	05	535.63			Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 grams or less and/or removal of surface myomas; vaginal approach
58146		1,138.67			Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach
58150		947.62			Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58152		1,247.48			Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)
58180		947.34			Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58200		1,314.34			Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)
58210		1,751.07			Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)
58240		2,328.24			Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
58260		816.38			Vaginal hysterectomy, for uterus 250 grams or less;
58262		919.44			Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s), and/or ovary(s)
58263		993.96			Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58267		1,050.96			Vaginal hysterectomy, for uterus 250 grams or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270		885.76			Vaginal hysterectomy, for uterus 250 grams or less; with repair of enterocele
58275		976.94			Vaginal hysterectomy, with total or partial vaginectomy;
58280		1,045.13			Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
58285		1,328.75			Vaginal hysterectomy, radical (Schauta type operation)

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
58290		1,135.76			Vaginal hysterectomy, for uterus greater than 250 grams;
58291		1,251.05			Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)
58292		1,325.99			Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s), with repair of enterocele
58293		1,382.95			Vaginal hysterectomy, for uterus greater than 250 grams; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58294		1,221.16			Vaginal hysterectomy, for uterus greater than 250 grams; with repair of enterocele
58300		101.54			Insertion of intrauterine device (IUD)
58301		108.75			Removal of intrauterine device (IUD)
58321		86.77			Artificial insemination; intra-cervical
58322		96.39			Artificial insemination; intra-uterine
58323		19.39			Sperm washing for artificial insemination
58340		292.48			Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58345		291.10			Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography
58346		442.92			Insertion of Heyman capsules for clinical brachytherapy
58350	03	104.92			Chromotubation of oviduct, including materials
58353	04	1,675.87			Endometrial ablation, thermal, without hysteroscopic guidance
58400		429.30			Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure)
58410		791.74			Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; with presacral sympathectomy
58520		746.91			Hysterorrhaphy, repair of ruptured uterus (nonobstetrical)
58540		891.74			Hysteroplasty, repair of uterine anomaly (Strassman type)
58545	09	905.38			Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas
58546	09	1,146.38			Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams
58550	09	894.68			Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less;
58552		992.86			Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)
58553		1,137.87			Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;
58554		1,313.81			Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)
58555	01	226.39			Hysteroscopy, diagnostic (separate procedure)
58558	03	283.28			Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
58559	02	365.23			Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)
58560	03	414.58			Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
58561	03	589.81			Hysteroscopy, surgical; with removal of leiomyomata
58562	03	308.14			Hysteroscopy, surgical; with removal of impacted foreign body
58563	04	365.65			Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)
58578		I.C.			Unlisted laparoscopy procedure, uterus
58579		I.C.			Unlisted hysteroscopy procedure, uterus
58600	03	366.53			Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605		332.95			Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)
58611		81.11			Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)
58615	04	275.74			Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach
58660	05	688.65			Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
58661	05	673.10			Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58662	05	730.92			Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method
58670	03	368.86			Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	03	370.30			Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)
58672	05	791.65			Laparoscopy, surgical; with fimbrioplasty
58673	05	847.54			Laparoscopy, surgical; with salpingostomy (salpingoneostomy)
58679		I.C.			Unlisted laparoscopy procedure, oviduct, ovary
58700		730.09			Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720		713.63			Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58740		850.31			Lysis of adhesions (salpingolysis, ovariolysis)
58750		926.10			Tubotubal anastomosis
58752		908.10			Tubouterine implantation
58760		827.50			Fimbrioplasty
58770	6	870.30			Salpingostomy (salpingoneostomy)
58800	03	357.91			Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); vaginal approach
58805		391.40			Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); abdominal approach
58820	03	310.05			Drainage of ovarian abscess; vaginal approach, open
58822		635.42			Drainage of ovarian abscess; abdominal approach
58823		180.89			Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
58825		681.13			Transposition, ovary(s)
58900	03	398.07			Biopsy of ovary, unilateral or bilateral (separate procedure)
58920		689.13			Wedge resection or bisection of ovary, unilateral or bilateral
58925		709.41			Ovarian cystectomy, unilateral or bilateral
58940		475.01			Oophorectomy, partial or total, unilateral or bilateral;
58943		1,129.88			Oophorectomy, partial or total, unilateral or bilateral; for ovarian, tubal or primary peritoneal malignancy, with para-aortic and pelvic lymph node biopsies, peritoneal washings, peritoneal biopsies, diaphragmatic assessments, with or without salpingectomy(s), with or without omentectomy
58950		1,051.69			Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy;
58951		1,367.01			Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy
58952		1,534.11			Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)
58953		1,940.06			Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;
58954		2,111.38			Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy
58960		918.82			Laparotomy, for staging or restaging of ovarian, tubal or primary peritoneal malignancy (second look), with or without omentectomy, peritoneal washing, biopsy of abdominal and pelvic peritoneum, diaphragmatic assessment with pelvic and limited para-aortic lymphadenectomy
58970		243.43			Follicle puncture for oocyte retrieval, any method
58974		I.C.			Embryo transfer, intrauterine
58976		269.43			Gamete, zygote, or embryo intrafallopian transfer, any method
58999		I.C.			Unlisted procedure, female genital system (nonobstetrical)
59000		145.94			Amniocentesis; diagnostic
59001		180.96			Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)
59012		217.97			Cordocentesis (intrauterine), any method
59015		163.54			Chorionic villus sampling, any method
59020		65.39	40.47	24.92	Fetal contraction stress test
59025		43.15	32.44	10.72	Fetal non-stress test
59030		132.20			Fetal scalp blood sampling
59050		54.43			Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation
59051		45.65			Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; interpretation only
59070		421.83			Transabdominal amnioinfusion, including ultrasound guidance
59072		491.35			Fetal umbilical cord occlusion, including ultrasound guidance

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
59074		400.33			Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance
59076		491.35			Fetal shunt placement, including ultrasound guidance
59100		818.18			Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)
59120		771.20			Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach
59121		782.56			Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy
59130		837.59			Surgical treatment of ectopic pregnancy; abdominal pregnancy
59135		918.23			Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy
59136		861.62			Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy with partial resection of uterus
59140		460.10			Surgical treatment of ectopic pregnancy; cervical, with evacuation
59150		738.74			Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy
59151		740.23			Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy
59160	03	257.73			Curettage, postpartum
59200		85.77			Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)
59300	01	197.53			Episiotomy or vaginal repair, by other than attending physician
59320	01	162.83			Cerclage of cervix, during pregnancy; vaginal
59325		260.43			Cerclage of cervix, during pregnancy; abdominal
59350		300.27			Hysterorrhaphy of ruptured uterus
59400		1,670.63			Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409		820.15			Vaginal delivery only (with or without episiotomy and/or forceps);
59410		919.39			Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59412		109.72			External cephalic version, with or without tocolysis
59414		97.76			Delivery of placenta (separate procedure)
59425		391.77			Antepartum care only; 4-6 visits
59426		688.31			Antepartum care only; 7 or more visits
59430		146.39			Postpartum care only (separate procedure)
59510		1,892.01			Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59514		967.54			Cesarean delivery only;
59515		1,098.39			Cesarean delivery only; including postpartum care
59525		517.09			Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)
59610		1,762.16			Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

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59612		920.79			Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);
59614		1,014.67			Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59618		2,003.19			Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59620		1,059.67			Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;
59622		1,200.83			Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care
59812	05	279.74			Treatment of incomplete abortion, any trimester, completed surgically
59820	05	325.31			Treatment of missed abortion, completed surgically; first trimester
59821	05	342.40			Treatment of missed abortion, completed surgically; second trimester
59830	02	438.95			Treatment of septic abortion, completed surgically
59840	05	222.79			Induced abortion, by dilation and curettage
59841	05	339.86			Induced abortion, by dilation and evacuation
59850		398.71			Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;
59851		419.28			Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation
59852		577.33			Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed intra-amniotic injection)
59855		420.36			Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines;
59856		501.84			Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation
59857		603.41			Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed medical evacuation)
59866	05	253.69			Multifetal pregnancy reduction(s) (MPR)
59870	05	440.89			Uterine evacuation and curettage for hydatidiform mole
59871	05	168.31			Removal of cerclage suture under anesthesia (other than local)
59897		I.C.			Unlisted fetal invasive procedure, including ultrasound guidance
59898		I.C.			Unlisted laparoscopy procedure, maternity care and delivery
59899		I.C.			Unlisted procedure, maternity care and delivery
60000	01	162.52			Incision and drainage of thyroglossal duct cyst, infected
60001		101.49			Aspiration and/or injection, thyroid cyst
60100		120.49			Biopsy thyroid, percutaneous core needle
60200	02	648.87			Excision of cyst or adenoma of thyroid, or transection of isthmus

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
60210		689.77			Partial thyroid lobectomy, unilateral; with or without isthmusectomy
60212		987.96			Partial thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy
60220		748.65			Total thyroid lobectomy, unilateral; with or without isthmusectomy
60225		900.00			Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy
60240		985.84			Thyroidectomy, total or complete
60252		1,267.41			Thyroidectomy, total or subtotal for malignancy; with limited neck dissection
60254		1,693.24			Thyroidectomy, total or subtotal for malignancy; with radical neck dissection
60260		1,081.11			Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid
60270		1,277.09			Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach
60271		1,052.52			Thyroidectomy, including substernal thyroid; cervical approach
60280	04	440.78			Excision of thyroglossal duct cyst or sinus;
60281	04	598.08			Excision of thyroglossal duct cyst or sinus; recurrent
60500		986.88			Parathyroidectomy or exploration of parathyroid(s);
60502		1,238.58			Parathyroidectomy or exploration of parathyroid(s); re-exploration
60505		1,355.38			Parathyroidectomy or exploration of parathyroid(s); with mediastinal exploration, sternal split or transthoracic approach
60512		252.04			Parathyroid autotransplantation (List separately in addition to code for primary procedure)
60520		1,052.60			Thymectomy, partial or total; transcervical approach (separate procedure)
60521		1,200.96			Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)
60522		1,450.30			Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)
60540		1,014.83			Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure);
60545		1,174.77			Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure); with excision of adjacent retroperitoneal tumor
60600		1,202.26			Excision of carotid body tumor; without excision of carotid artery
60605		1,383.73			Excision of carotid body tumor; with excision of carotid artery
60650		1,161.55			Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal
60659		I.C.			Unlisted laparoscopy procedure, endocrine system
60699		I.C.			Unlisted procedure, endocrine system
61000		104.85			Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; initial
61001		106.27			Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; subsequent taps
61020	01	123.15			Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection

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61026	01	130.66			Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; with injection of medication or other substance for diagnosis or treatment
61050	01	114.85			Cisternal or lateral cervical (C1-C2) puncture; without injection (separate procedure)
61055	01	143.85			Cisternal or lateral cervical (C1-C2) puncture; with injection of medication or other substance for diagnosis or treatment (eg, C1-C2)
61070	01	80.28			Puncture of shunt tubing or reservoir for aspiration or injection procedure
61105		398.04			Twist drill hole for subdural or ventricular puncture;
61107		365.01			Twist drill hole for subdural or ventricular puncture; for implanting ventricular catheter or pressure recording device
61108		758.25			Twist drill hole for subdural or ventricular puncture; for evacuation and/or drainage of subdural hematoma
61120		648.25			Burr hole(s) for ventricular puncture (including injection of gas, contrast media, dye, or radioactive material)
61140		1,130.52			Burr hole(s) or trephine; with biopsy of brain or intracranial lesion
61150		1,227.69			Burr hole(s) or trephine; with drainage of brain abscess or cyst
61151		886.97			Burr hole(s) or trephine; with subsequent tapping (aspiration) of intracranial abscess or cyst
61154		1,075.33			Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural
61156		1,153.85			Burr hole(s); with aspiration of hematoma or cyst, intracerebral
61210		418.22			Burr hole(s); for implanting ventricular catheter, reservoir, EEG electrode(s) or pressure recording device (separate procedure)
61215	03	389.17			Insertion of subcutaneous reservoir, pump or continuous infusion system for connection to ventricular catheter
61250		754.95			Burr hole(s) or trephine, supratentorial, exploratory, not followed by other surgery
61253		873.47			Burr hole(s) or trephine, infratentorial, unilateral or bilateral
61304		1,526.45			Craniectomy or craniotomy, exploratory; supratentorial
61305		1,839.67			Craniectomy or craniotomy, exploratory; infratentorial (posterior fossa)
61312		1,741.22			Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural
61313		1,747.80			Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral
61314		1,608.11			Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural
61315		1,923.02			Craniectomy or craniotomy for evacuation of hematoma, infratentorial; intracerebellar
61316		92.04			Incision and subcutaneous placement of cranial bone graft (List separately in addition to code for primary procedure)
61320		1,776.51			Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial
61321		1,948.68			Craniectomy or craniotomy, drainage of intracranial abscess; infratentorial
61322		1,900.57			Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy
61323		1,964.77			Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					hematoma; with lobectomy
61330		1,553.25			Decompression of orbit only, transcranial approach
61332		1,837.58			Exploration of orbit (transcranial approach); with biopsy
61333		1,793.59			Exploration of orbit (transcranial approach); with removal of lesion
61334		1,248.03			Exploration of orbit (transcranial approach); with removal of foreign body
61340		1,305.21			Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome)
61343		2,050.97			Craniectomy, suboccipital with cervical laminectomy for decompression of medulla and spinal cord, with or without dural graft (eg, Arnold-Chiari malformation)
61345		1,865.53			Other cranial decompression, posterior fossa
61440		1,806.17			Craniotomy for section of tentorium cerebelli (separate procedure)
61450		1,766.68			Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion
61458		1,875.36			Craniectomy, suboccipital; for exploration or decompression of cranial nerves
61460		1,949.81			Craniectomy, suboccipital; for section of one or more cranial nerves
61470		1,735.79			Craniectomy, suboccipital; for medullary tractotomy
61480		1,844.37			Craniectomy, suboccipital; for mesencephalic tractotomy or pedunculotomy
61490		1,767.03			Craniotomy for lobotomy, including cingulotomy
61500		1,249.84			Craniectomy; with excision of tumor or other bone lesion of skull
61501		1,043.84			Craniectomy; for osteomyelitis
61510		1,986.54			Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma
61512		2,412.49			Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial
61514		1,747.59			Craniectomy, trephination, bone flap craniotomy; for excision of brain abscess, supratentorial
61516		1,709.31			Craniectomy, trephination, bone flap craniotomy; for excision or fenestration of cyst, supratentorial
61517		79.07			Implantation of brain intracavitary chemotherapy agent (List separately in addition to code for primary procedure)
61518		2,571.00			Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull
61519		2,812.31			Craniectomy for excision of brain tumor, infratentorial or posterior fossa; meningioma
61520		3,714.23			Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor
61521		3,020.25			Craniectomy for excision of brain tumor, infratentorial or posterior fossa; midline tumor at base of skull
61522		1,995.78			Craniectomy, infratentorial or posterior fossa; for excision of brain abscess
61524		1,893.71			Craniectomy, infratentorial or posterior fossa; for excision or fenestration of cyst
61526		3,455.81			Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;
61530		2,936.28			Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; combined with middle/posterior fossa

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					craniotomy/craniectomy
61531		1,040.34			Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring
61533		1,368.03			Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring
61534		1,452.04			Craniotomy with elevation of bone flap; for excision of epileptogenic focus without electrocorticography during surgery
61535		835.04			Craniotomy with elevation of bone flap; for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)
61536		2,416.85			Craniotomy with elevation of bone flap; for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)
61537		1,744.97			Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery
61538		1,852.43			Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, with electrocorticography during surgery
61539		2,199.58			Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, with electrocorticography during surgery
61540		2,105.92			Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery
61541		1,971.49			Craniotomy with elevation of bone flap; for transection of corpus callosum
61542		2,157.64			Craniotomy with elevation of bone flap; for total hemispherectomy
61543		2,015.22			Craniotomy with elevation of bone flap; for partial or subtotal (functional) hemispherectomy
61544		1,723.55			Craniotomy with elevation of bone flap; for excision or coagulation of choroid plexus
61545		2,995.80			Craniotomy with elevation of bone flap; for excision of craniopharyngioma
61546		2,138.70			Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach
61548		1,483.78			Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic
61550		888.28			Craniectomy for craniosynostosis; single cranial suture
61552		1,156.09			Craniectomy for craniosynostosis; multiple cranial sutures
61556		1,448.93			Craniotomy for craniosynostosis; frontal or parietal bone flap
61557		1,588.60			Craniotomy for craniosynostosis; bifrontal bone flap
61558		1,658.27			Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); not requiring bone grafts
61559		2,299.97			Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); recontouring with multiple osteotomies and bone autografts (eg, barrel-stave procedure) (includes obtaining grafts)
61563		1,817.79			Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); without optic nerve decompression
61564		2,304.28			Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); with optic nerve decompression
61566		2,096.05			Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy
61567		2,405.28			Craniotomy with elevation of bone flap; for multiple subpial transections, with electrocorticography during surgery

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
61570		1,681.47			Craniectomy or craniotomy; with excision of foreign body from brain
61571		1,824.03			Craniectomy or craniotomy; with treatment of penetrating wound of brain
61575		2,307.37			Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion;
61576		3,394.39			Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion; requiring splitting of tongue and/or mandible (including tracheostomy)
61580		2,316.68			Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration
61581		2,396.28			Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy
61582		2,557.63			Craniofacial approach to anterior cranial fossa; extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior cranial fossa
61583		2,668.84			Craniofacial approach to anterior cranial fossa; intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa
61584		2,570.03			Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); without orbital exenteration
61585		2,793.11			Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); with orbital exenteration
61586		2,014.60			Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft
61590		2,942.45			Infratemporal pre-auricular approach to middle cranial fossa (parapharyngeal space, infratemporal and midline skull base, nasopharynx), with or without disarticulation of the mandible, including parotidectomy, craniotomy, decompression and/or mobilization of the facial nerve and/or petrous carotid artery
61591		3,087.05			Infratemporal post-auricular approach to middle cranial fossa (internal auditory meatus, petrous apex, tentorium, cavernous sinus, parasellar area, infratemporal fossa) including mastoidectomy, resection of sigmoid sinus, with or without decompression and/or mobilization of contents of auditory canal or petrous carotid artery
61592		2,887.02			Orbitocranial zygomatic approach to middle cranial fossa (cavernous sinus and carotid artery, clivus, basilar artery or petrous apex) including osteotomy of zygoma, craniotomy, extra- or intradural elevation of temporal lobe
61595		2,172.82			Transtemporal approach to posterior cranial fossa, jugular foramen or midline skull base, including mastoidectomy, decompression of sigmoid sinus and/or facial nerve, with or without mobilization
61596		2,532.12			Transcochlear approach to posterior cranial fossa, jugular foramen or midline skull base, including labyrinthectomy, decompression, with or without mobilization of facial nerve and/or petrous carotid artery
61597		2,641.34			Transcondylar (far lateral) approach to posterior cranial fossa, jugular foramen or midline skull base, including occipital condylectomy, mastoidectomy, resection of C1-C3 vertebral body(s), decompression of vertebral artery, with or without mobilization

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
61598		2,408.73			Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus
61600		1,924.07			Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; extradural
61601		2,108.21			Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; intradural, including dural repair, with or without graft
61605		2,129.52			Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; extradural
61606		2,771.74			Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; intradural, including dural repair, with or without graft
61607		2,578.20			Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural
61608		3,010.03			Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; intradural, including dural repair, with or without graft
61609		652.83			Transection or ligation, carotid artery in cavernous sinus; without repair (List separately in addition to code for primary procedure)
61610		1,800.80			Transection or ligation, carotid artery in cavernous sinus; with repair by anastomosis or graft (List separately in addition to code for primary procedure)
61611		497.37			Transection or ligation, carotid artery in petrous canal; without repair (List separately in addition to code for primary procedure)
61612		1,741.37			Transection or ligation, carotid artery in petrous canal; with repair by anastomosis or graft (List separately in addition to code for primary procedure)
61613		2,949.65			Obliteration of carotid aneurysm, arteriovenous malformation, or carotid-cavernous fistula by dissection within cavernous sinus
61615		2,337.35			Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C1-C3 vertebral bodies; extradural
61616		3,098.46			Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C1-C3 vertebral bodies; intradural, including dural repair, with or without graft
61618		1,188.15			Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by free tissue graft (eg, pericranium, fascia, tensor fascia lata, adipose tissue, homologous or synthetic grafts)
61619		1,422.30			Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by local or regionalized vascularized pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle)
61623		571.52			Endovascular temporary balloon arterial occlusion, head or neck (extracranial/intracranial) including selective catheterization of vessel to be occluded, positioning and inflation of occlusion balloon, concomitant neurological monitoring, and radiologic supervision and interpretation of all angiography required for balloon occlusion and to exclude vascular injury post occlusion
61624		1,092.54			Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)
61626		889.81			Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method;

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					non-central nervous system, head or neck (extracranial, brachiocephalic branch)
61680		2,113.02			Surgery of intracranial arteriovenous malformation; supratentorial, simple
61682		4,142.00			Surgery of intracranial arteriovenous malformation; supratentorial, complex
61684		2,715.13			Surgery of intracranial arteriovenous malformation; infratentorial, simple
61686		4,375.84			Surgery of intracranial arteriovenous malformation; infratentorial, complex
61690		2,011.36			Surgery of intracranial arteriovenous malformation; dural, simple
61692		3,484.79			Surgery of intracranial arteriovenous malformation; dural, complex
61697		3,460.60			Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation
61698		3,313.95			Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation
61700		3,447.67			Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation
61702		3,277.85			Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation
61703		1,232.16			Surgery of intracranial aneurysm, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type)
61705		2,419.56			Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery
61708		2,048.90			Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial electrothrombosis
61710		1,780.74			Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intra-arterial embolization, injection procedure, or balloon catheter
61711		2,474.15			Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/cortical) arteries
61720		1,180.91			Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus
61735		1,434.93			Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; subcortical structure(s) other than globus pallidus or thalamus
61750		1,269.01			Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion;
61751		1,250.35			Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance
61760		1,374.48			Stereotactic implantation of depth electrodes into the cerebrum for long term seizure monitoring
61770		1,474.11			Stereotactic localization, including burr hole(s), with insertion of catheter(s) or probe(s) for placement of radiation source
61790	03	725.56			Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); gasserian ganglion
61791	03	1,037.33			Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); trigeminal medullary tract
61793		1,204.11			Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions
61795		267.35			Stereotactic computer assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (List separately in addition to code for primary procedure)
61850		872.14			Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
61860		1,443.23			Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical
61863		1,247.22			Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array
61864		299.73			Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)
61867		1,905.73			Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array
61868		504.45			Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)
61870		1,038.06			Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortical
61875		1,017.66			Craniectomy for implantation of neurostimulator electrodes, cerebellar; subcortical
61880		478.10			Revision or removal of intracranial neurostimulator electrodes
61885	02	488.56			Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61886	03	628.77			Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays
61888	01	391.85			Revision or removal of cranial neurostimulator pulse generator or receiver
62000		737.20			Elevation of depressed skull fracture; simple, extradural
62005		1,065.50			Elevation of depressed skull fracture; compound or comminuted, extradural
62010		1,387.54			Elevation of depressed skull fracture; with repair of dura and/or debridement of brain
62100		1,518.53			Craniotomy for repair of dural/cerebrospinal fluid leak, including surgery for rhinorrhea/otorrhea
62115		1,472.16			Reduction of craniomegalic skull (eg, treated hydrocephalus); not requiring bone grafts or cranioplasty
62116		1,629.19			Reduction of craniomegalic skull (eg, treated hydrocephalus); with simple cranioplasty
62117		1,853.63			Reduction of craniomegalic skull (eg, treated hydrocephalus); requiring craniotomy and reconstruction with or without bone graft (includes obtaining grafts)
62120		1,594.04			Repair of encephalocele, skull vault, including cranioplasty
62121		1,439.48			Craniotomy for repair of encephalocele, skull base
62140		955.27			Cranioplasty for skull defect; up to 5 cm diameter
62141		1,048.25			Cranioplasty for skull defect; larger than 5 cm diameter
62142		778.34			Removal of bone flap or prosthetic plate of skull

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
62143		924.32			Replacement of bone flap or prosthetic plate of skull
62145		1,308.09			Cranioplasty for skull defect with reparative brain surgery
62146		1,121.63			Cranioplasty with autograft (includes obtaining bone grafts); up to 5 cm diameter
62147		1,339.53			Cranioplasty with autograft (includes obtaining bone grafts); larger than 5 cm diameter
62148		125.58			Incision and retrieval of subcutaneous cranial bone graft for cranioplasty (List separately in addition to code for primary procedure)
62160		180.08			Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage (List separately in addition to code for primary procedure)
62161		1,289.80			Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (including placement, replacement, or removal of ventricular catheter)
62162		1,652.14			Neuroendoscopy, intracranial; with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage
62163		1,048.39			Neuroendoscopy, intracranial; with retrieval of foreign body
62164		1,788.00			Neuroendoscopy, intracranial; with excision of brain tumor, including placement of external ventricular catheter for drainage
62165		1,402.86			Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach
62180		1,469.44			Ventriculocisternostomy (Torkildsen type operation)
62190		795.27			Creation of shunt; subarachnoid/subdural-atrial, -jugular, -auricular
62192		873.15			Creation of shunt; subarachnoid/subdural-peritoneal, -pleural, other terminus
62194	01	324.91			Replacement or irrigation, subarachnoid/subdural catheter
62200		1,282.51			Ventriculocisternostomy, third ventricle;
62201		1,050.81			Ventriculocisternostomy, third ventricle; stereotactic, neuroendoscopic method
62220		919.01			Creation of shunt; ventriculo-atrial, -jugular, -auricular
62223		926.86			Creation of shunt; ventriculo-peritoneal, -pleural, other terminus
62225	01	416.17			Replacement or irrigation, ventricular catheter
62230	02	746.99			Replacement or revision of cerebrospinal fluid shunt, obstructed valve, or distal catheter in shunt system
62252		96.59	49.20	47.39	Reprogramming of programmable cerebrospinal shunt
62256		496.05			Removal of complete cerebrospinal fluid shunt system; without replacement
62258		1,021.22			Removal of complete cerebrospinal fluid shunt system; with replacement by similar or other shunt at same operation
62263	01	746.82			Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264		500.37			Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
62268	01	634.85			Percutaneous aspiration, spinal cord cyst or syrinx
62269	01	738.99			Biopsy of spinal cord, percutaneous needle

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
62270	01	174.55			Spinal puncture, lumbar, diagnostic
62272	01	210.83			Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)
62273	01	201.26			Injection, epidural, of blood or clot patch
62280	01	383.27			Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid
62281	01	348.81			Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic
62282	01	438.63			Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)
62284		267.38			Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)
62287	09	561.00			Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous diskectomy, percutaneous laser diskectomy)
62290		407.40			Injection procedure for diskography, each level; lumbar
62291		355.89			Injection procedure for diskography, each level; cervical or thoracic
62292		509.11			Injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar
62294	03	713.15			Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal
62310	01	279.53			Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
62311	01	268.35			Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)
62318	01	313.40			Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
62319	01	277.60			Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)
62350	02	449.98			Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy
62351		740.78			Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy
62355	02	357.13			Removal of previously implanted intrathecal or epidural catheter
62360	02	220.53			Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
62361	02	386.83			Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump
62362	02	480.92			Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming
62365	02	376.76			Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion
62367			24.78		Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming
62368			38.09		Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming
63001		1,106.57			Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), one or two vertebral segments; cervical
63003		1,124.01			Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), one or two vertebral segments; thoracic
63005		1,075.22			Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), one or two vertebral segments; lumbar, except for spondylolisthesis
63011		946.57			Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), one or two vertebral segments; sacral
63012		1,103.37			Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63015		1,368.60			Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical
63016		1,350.93			Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), more than 2 vertebral segments; thoracic
63017		1,142.31			Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), more than 2 vertebral segments; lumbar
63020		1,070.01			Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, cervical
63030		885.50			Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach)
63035		206.50			Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
63040		1,314.41			Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; cervical

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
63042		1,246.45			Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; lumbar
63043		I.C.			Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)
63044		I.C.			Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)
63045		1,173.20			Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; cervical
63046		1,128.00			Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; thoracic
63047		1,059.86			Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; lumbar
63048		214.32			Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)
63055		1,529.84			Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disk), single segment; thoracic
63056		1,416.10			Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disk), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disk)
63057		338.65			Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disk), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)
63064		1,706.28			Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disk), thoracic; single segment
63066		216.12			Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disk), thoracic; each additional segment (List separately in addition to code for primary procedure)
63075		1,374.97			Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
63076		267.37			Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)
63077		1,469.70			Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace
63078		210.81			Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, each additional interspace (List separately in addition to code for primary procedure)
63081		1,658.74			Vertebral corpectomy (vertebral body resection), partial or complete, anterior

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					approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63082		288.10			Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)
63085		1,835.78			Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment
63086		207.53			Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, each additional segment (List separately in addition to code for primary procedure)
63087		2,371.65			Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment
63088		282.69			Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; each additional segment (List separately in addition to code for primary procedure)
63090		1,889.72			Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment
63091		192.00			Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (List separately in addition to code for primary procedure)
63101		2,190.71			Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment
63102		2,190.71			Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); lumbar, single segment
63103		254.21			Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure)
63170		1,395.66			Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic, or thoracolumbar
63172		1,247.24			Laminectomy with drainage of intramedullary cyst/syrinx; to subarachnoid space
63173		1,527.00			Laminectomy with drainage of intramedullary cyst/syrinx; to peritoneal or pleural space
63180		1,298.91			Laminectomy and section of dentate ligaments, with or without dural graft, cervical; one or two segments
63182		1,369.14			Laminectomy and section of dentate ligaments, with or without dural graft, cervical; more than two segments
63185		989.44			Laminectomy with rhizotomy; one or two segments
63190		1,195.57			Laminectomy with rhizotomy; more than two segments
63191		1,237.04			Laminectomy with section of spinal accessory nerve
63194		1,368.86			Laminectomy with cordotomy, with section of one spinothalamic tract, one stage;

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					cervical
63195		1,307.57			Laminectomy with cordotomy, with section of one spinothalamic tract, one stage; thoracic
63196		1,580.77			Laminectomy with cordotomy, with section of both spinothalamic tracts, one stage; cervical
63197		1,477.03			Laminectomy with cordotomy, with section of both spinothalamic tracts, one stage; thoracic
63198		1,511.26			Laminectomy with cordotomy with section of both spinothalamic tracts, two stages within 14 days; cervical
63199		1,858.24			Laminectomy with cordotomy with section of both spinothalamic tracts, two stages within 14 days; thoracic
63200		1,336.51			Laminectomy, with release of tethered spinal cord, lumbar
63250		2,655.90			Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical
63251		2,796.32			Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracic
63252		2,772.67			Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumbar
63265		1,506.91			Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
63266		1,558.70			Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic
63267		1,269.79			Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
63268		1,251.65			Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral
63270		1,859.15			Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical
63271		1,873.71			Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic
63272		1,757.45			Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar
63273		1,704.87			Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; sacral
63275		1,643.57			Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical
63276		1,628.46			Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic
63277		1,458.71			Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar
63278		1,441.90			Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacral
63280		1,967.53			Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical
63281		1,945.09			Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, thoracic
63282		1,834.79			Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, lumbar
63283		1,746.63			Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, sacral
63285		2,463.64			Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary,

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					cervical
63286		2,439.31			Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic
63287		2,517.58			Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar
63290		2,555.00			Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level
63300		1,697.25			Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical
63301		1,878.06			Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by transthoracic approach
63302		1,906.42			Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by thoracolumbar approach
63303		2,049.82			Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, lumbar or sacral by transperitoneal or retroperitoneal approach
63304		2,043.43			Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, cervical
63305		2,162.17			Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by transthoracic approach
63306		2,051.53			Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by thoracolumbar approach
63307		2,052.84			Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, lumbar or sacral by transperitoneal or retroperitoneal approach
63308		344.63			Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; each additional segment (List separately in addition to codes for single segment)
63600	02	801.34			Creation of lesion of spinal cord by stereotactic method, percutaneous, any modality (including stimulation and/or recording)
63610	01	2,690.72			Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery
63615		1,112.98			Stereotactic biopsy, aspiration, or excision of lesion, spinal cord
63650	02	406.92			Percutaneous implantation of neurostimulator electrode array, epidural
63655		745.01			Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63660	01	408.33			Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)
63685	02	475.25			Incision and subcutaneous placement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63688	01	378.56			Revision or removal of implanted spinal neurostimulator pulse generator or receiver
63700		1,152.67			Repair of meningocele; less than 5 cm diameter
63702		1,201.88			Repair of meningocele; larger than 5 cm diameter
63704		1,479.76			Repair of myelomeningocele; less than 5 cm diameter
63706		1,652.31			Repair of myelomeningocele; larger than 5 cm diameter
63707		818.37			Repair of dural/cerebrospinal fluid leak, not requiring laminectomy

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
63709		1,023.77			Repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy
63710		1,005.77			Dural graft, spinal
63740		816.39			Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other; including laminectomy
63741		550.31			Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other; percutaneous, not requiring laminectomy
63744	03	582.22			Replacement, irrigation or revision of lumbosubarachnoid shunt
63746	02	443.96			Removal of entire lumbosubarachnoid shunt system without replacement
64400		128.69			Injection, anesthetic agent; trigeminal nerve, any division or branch
64402		122.88			Injection, anesthetic agent; facial nerve
64405		116.85			Injection, anesthetic agent; greater occipital nerve
64408		123.07			Injection, anesthetic agent; vagus nerve
64410	01	164.84			Injection, anesthetic agent; phrenic nerve
64412		161.73			Injection, anesthetic agent; spinal accessory nerve
64413		135.34			Injection, anesthetic agent; cervical plexus
64415	01	178.53			Injection, anesthetic agent; brachial plexus, single
64416		164.96			Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration
64417	01	187.86			Injection, anesthetic agent; axillary nerve
64418		163.88			Injection, anesthetic agent; suprascapular nerve
64420	01	195.70			Injection, anesthetic agent; intercostal nerve, single
64421	01	294.16			Injection, anesthetic agent; intercostal nerves, multiple, regional block
64425		141.55			Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves
64430	01	168.13			Injection, anesthetic agent; pudendal nerve
64435		168.83			Injection, anesthetic agent; paracervical (uterine) nerve
64445		172.20			Injection, anesthetic agent; sciatic nerve, single
64446		175.30			Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter, (including catheter placement) including daily management for anesthetic agent administration
64447		81.06			Injection, anesthetic agent; femoral nerve, single
64448		159.55			Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration
64449		157.02			Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration
64450		104.00			Injection, anesthetic agent; other peripheral nerve or branch
64470	01	278.83			Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level
64472	01	133.72			Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
64475	01	248.69			Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level
64476	01	115.78			Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64479	01	385.25			Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level
64480	01	162.96			Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64483	01	393.27			Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level
64484	01	171.18			Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64505		105.71			Injection, anesthetic agent; sphenopalatine ganglion
64508		169.11			Injection, anesthetic agent; carotid sinus (separate procedure)
64510	01	183.30			Injection, anesthetic agent; stellate ganglion (cervical sympathetic)
64517		200.68			Injection, anesthetic agent; superior hypogastric plexus
64520	01	246.13			Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)
64530	01	228.97			Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring
64550		19.73			Application of surface (transcutaneous) neurostimulator
64553	01	207.22			Percutaneous implantation of neurostimulator electrodes; cranial nerve
64555		219.76			Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve)
64560		206.58			Percutaneous implantation of neurostimulator electrodes; autonomic nerve
64561		390.90			Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)
64565		210.58			Percutaneous implantation of neurostimulator electrodes; neuromuscular
64573	01	556.59			Incision for implantation of neurostimulator electrodes; cranial nerve
64575	01	290.97			Incision for implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve)
64577	01	331.79			Incision for implantation of neurostimulator electrodes; autonomic nerve
64580	01	312.13			Incision for implantation of neurostimulator electrodes; neuromuscular
64581		749.89			Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)
64585	01	575.90			Revision or removal of peripheral neurostimulator electrodes
64590	02	410.93			Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling
64595	01	523.96			Revision or removal of peripheral neurostimulator pulse generator or receiver
64600	01	496.12			Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch
64605	01	592.47			Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
64610	01	642.70			Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring
64612		187.65			Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)
64613		202.71			Chemodenervation of muscle(s); cervical spinal muscle(s) (eg, for spasmodic torticollis)
64614		222.84			Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)
64620	01	307.30			Destruction by neurolytic agent, intercostal nerve
64622	01	440.64			Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level
64623	01	141.44			Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64626	01	412.95			Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level
64627	01	156.76			Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64630	02	233.91			Destruction by neurolytic agent; pudendal nerve
64640		286.71			Destruction by neurolytic agent; other peripheral nerve or branch
64680	02	355.86			Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus
64681		506.05			Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus
64702	01	338.76			Neuroplasty; digital, one or both, same digit
64704	01	331.51			Neuroplasty; nerve of hand or foot
64708	02	463.70			Neuroplasty, major peripheral nerve, arm or leg; other than specified
64712	02	521.72			Neuroplasty, major peripheral nerve, arm or leg; sciatic nerve
64713	02	699.35			Neuroplasty, major peripheral nerve, arm or leg; brachial plexus
64714	02	590.62			Neuroplasty, major peripheral nerve, arm or leg; lumbar plexus
64716	03	480.59			Neuroplasty and/or transposition; cranial nerve (specify)
64718	02	504.43			Neuroplasty and/or transposition; ulnar nerve at elbow
64719	02	393.31			Neuroplasty and/or transposition; ulnar nerve at wrist
64721	02	391.35			Neuroplasty and/or transposition; median nerve at carpal tunnel
64722	01	317.55			Decompression; unspecified nerve(s) (specify)
64726	01	294.29			Decompression; plantar digital nerve
64727	01	194.95			Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)
64732	02	342.61			Transection or avulsion of; supraorbital nerve
64734	02	386.29			Transection or avulsion of; infraorbital nerve
64736	02	368.76			Transection or avulsion of; mental nerve
64738	02	440.74			Transection or avulsion of; inferior alveolar nerve by osteotomy
64740	02	411.07			Transection or avulsion of; lingual nerve

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
64742	02	458.88			Transection or avulsion of; facial nerve, differential or complete
64744	02	392.37			Transection or avulsion of; greater occipital nerve
64746	02	441.19			Transection or avulsion of; phrenic nerve
64752		477.53			Transection or avulsion of; vagus nerve (vagotomy), transthoracic
64755		790.50			Transection or avulsion of; vagus nerves limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy)
64760		429.06			Transection or avulsion of; vagus nerve (vagotomy), abdominal
64761		400.71			Transection or avulsion of; pudendal nerve
64763		509.73			Transection or avulsion of obturator nerve, extrapelvic, with or without adductor tenotomy
64766		583.98			Transection or avulsion of obturator nerve, intrapelvic, with or without adductor tenotomy
64771	02	559.69			Transection or avulsion of other cranial nerve, extradural
64772	02	522.81			Transection or avulsion of other spinal nerve, extradural
64774	02	376.78			Excision of neuroma; cutaneous nerve, surgically identifiable
64776	03	370.19			Excision of neuroma; digital nerve, one or both, same digit
64778	02	194.30			Excision of neuroma; digital nerve, each additional digit (List separately in addition to code for primary procedure)
64782	03	421.12			Excision of neuroma; hand or foot, except digital nerve
64783	02	235.28			Excision of neuroma; hand or foot, each additional nerve, except same digit (List separately in addition to code for primary procedure)
64784	03	689.17			Excision of neuroma; major peripheral nerve, except sciatic
64786	03	1,077.40			Excision of neuroma; sciatic nerve
64787	02	271.95			Implantation of nerve end into bone or muscle (List separately in addition to neuroma excision)
64788	03	339.23			Excision of neurofibroma or neurolemmoma; cutaneous nerve
64790	03	789.70			Excision of neurofibroma or neurolemmoma; major peripheral nerve
64792	03	1,002.59			Excision of neurofibroma or neurolemmoma; extensive (including malignant type)
64795	02	194.93			Biopsy of nerve
64802	02	594.09			Sympathectomy, cervical
64804		919.60			Sympathectomy, cervicothoracic
64809		794.02			Sympathectomy, thoracolumbar
64818		651.32			Sympathectomy, lumbar
64820		732.30			Sympathectomy; digital arteries, each digit
64821	04	675.10			Sympathectomy; radial artery
64822		671.73			Sympathectomy; ulnar artery
64823		777.40			Sympathectomy; superficial palmar arch
64831	04	693.87			Suture of digital nerve, hand or foot; one nerve
64832	01	362.01			Suture of digital nerve, hand or foot; each additional digital nerve (List separately in

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					addition to code for primary procedure)
64834	02	726.34			Suture of one nerve, hand or foot; common sensory nerve
64835	03	784.29			Suture of one nerve, hand or foot; median motor thenar
64836	03	781.95			Suture of one nerve, hand or foot; ulnar motor
64837	01	401.48			Suture of each additional nerve, hand or foot (List separately in addition to code for primary procedure)
64840	02	870.46			Suture of posterior tibial nerve
64856	02	967.97			Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64857	02	1,014.76			Suture of major peripheral nerve, arm or leg, except sciatic; without transposition
64858	02	1,174.27			Suture of sciatic nerve
64859	01	271.00			Suture of each additional major peripheral nerve (List separately in addition to code for primary procedure)
64861	03	1,311.55			Suture of; brachial plexus
64862	03	1,325.47			Suture of; lumbar plexus
64864	03	854.74			Suture of facial nerve; extracranial
64865	04	1,039.49			Suture of facial nerve; infratemporal, with or without grafting
64866		1,040.50			Anastomosis; facial-spinal accessory
64868		953.28			Anastomosis; facial-hypoglossal
64870	04	1,010.06			Anastomosis; facial-phrenic
64872	02	129.69			Suture of nerve; requiring secondary or delayed suture (List separately in addition to code for primary neurorrhaphy)
64874	03	189.59			Suture of nerve; requiring extensive mobilization, or transposition of nerve (List separately in addition to code for nerve suture)
64876	03	195.13			Suture of nerve; requiring shortening of bone of extremity (List separately in addition to code for nerve suture)
64885	02	1,174.40			Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length
64886	02	1,381.49			Nerve graft (includes obtaining graft), head or neck; more than 4 cm length
64890	02	1,054.64			Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length
64891	02	979.30			Nerve graft (includes obtaining graft), single strand, hand or foot; more than 4 cm length
64892	02	984.86			Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64893	02	1,068.30			Nerve graft (includes obtaining graft), single strand, arm or leg; more than 4 cm length
64895	03	1,206.19			Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length
64896	03	1,302.54			Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
64897	03	1,233.95			Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length
64898	03	1,330.11			Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; more than 4 cm length
64901	02	643.32			Nerve graft, each additional nerve; single strand (List separately in addition to code

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					for primary procedure)
64902	02	737.74			Nerve graft, each additional nerve; multiple strands (cable) (List separately in addition to code for primary procedure)
64905	02	943.66			Nerve pedicle transfer; first stage
64907	01	1,300.65			Nerve pedicle transfer; second stage
64999		I.C.			Unlisted procedure, nervous system
65091	03	662.69			Evisceration of ocular contents; without implant
65093	03	694.22			Evisceration of ocular contents; with implant
65101	03	725.13			Enucleation of eye; without implant
65103	03	754.10			Enucleation of eye; with implant, muscles not attached to implant
65105	04	817.69			Enucleation of eye; with implant, muscles attached to implant
65110	05	1,165.77			Exenteration of orbit (does not include skin graft), removal of orbital contents; only
65112	07	1,363.29			Exenteration of orbit (does not include skin graft), removal of orbital contents; with therapeutic removal of bone
65114	07	1,414.65			Exenteration of orbit (does not include skin graft), removal of orbital contents; with muscle or myocutaneous flap
65125		512.14			Modification of ocular implant with placement or replacement of pegs (eg, drilling receptacle for prosthesis appendage) (separate procedure)
65130	03	711.10			Insertion of ocular implant secondary; after evisceration, in scleral shell
65135	02	725.78			Insertion of ocular implant secondary; after enucleation, muscles not attached to implant
65140	03	771.37			Insertion of ocular implant secondary; after enucleation, muscles attached to implant
65150	02	636.30			Reinsertion of ocular implant; with or without conjunctival graft
65155	03	829.15			Reinsertion of ocular implant; with use of foreign material for reinforcement and/or attachment of muscles to implant
65175	01	652.53			Removal of ocular implant
65205		53.27			Removal of foreign body, external eye; conjunctival superficial
65210		64.07			Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating
65220		53.87			Removal of foreign body, external eye; corneal, without slit lamp
65222		68.61			Removal of foreign body, external eye; corneal, with slit lamp
65235	02	601.92			Removal of foreign body, intraocular; from anterior chamber of eye or lens
65260	03	909.97			Removal of foreign body, intraocular; from posterior segment, magnetic extraction, anterior or posterior route
65265	04	1,026.10			Removal of foreign body, intraocular; from posterior segment, nonmagnetic extraction
65270	02	236.10			Repair of laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure
65272	02	393.02			Repair of laceration; conjunctiva, by mobilization and rearrangement, without hospitalization
65273		407.66			Repair of laceration; conjunctiva, by mobilization and rearrangement, with hospitalization

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
65275	04	449.48			Repair of laceration; cornea, nonperforating, with or without removal foreign body
65280	04	643.68			Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue
65285	04	1,026.17			Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue
65286		569.84			Repair of laceration; application of tissue glue, wounds of cornea and/or sclera
65290	03	485.67			Repair of wound, extraocular muscle, tendon and/or Tenon's capsule
65400	01	600.63			Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium
65410	02	130.04			Biopsy of cornea
65420	02	480.59			Excision or transposition of pterygium; without graft
65426	05	520.53			Excision or transposition of pterygium; with graft
65430		266.20			Scraping of cornea, diagnostic, for smear and/or culture
65435		91.84			Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)
65436		410.53			Removal of corneal epithelium; with application of chelating agent (eg, EDTA)
65450		432.46			Destruction of lesion of cornea by cryotherapy, photocoagulation or thermocauterization
65600		370.26			Multiple punctures of anterior cornea (eg, for corneal erosion, tattoo)
65710	07	1,002.42			Keratoplasty (corneal transplant); lamellar
65730	07	1,056.96			Keratoplasty (corneal transplant); penetrating (except in aphakia)
65750	07	1,148.95			Keratoplasty (corneal transplant); penetrating (in aphakia)
65755	07	1,140.71			Keratoplasty (corneal transplant); penetrating (in pseudophakia)
65760		I.C.			Keratomileusis
65765		I.C.			Keratophakia
65767		I.C.			Epikeratoplasty
65770	07	1,289.18			Keratoprosthesis
65771		I.C.			Radial keratotomy
65772	04	469.10			Corneal relaxing incision for correction of surgically induced astigmatism
65775	04	535.89			Corneal wedge resection for correction of surgically induced astigmatism
65780		815.28			Ocular surface reconstruction; amniotic membrane transplantation
65781		1,236.78			Ocular surface reconstruction; limbal stem cell allograft (eg, cadaveric or living donor)
65782		1,066.92			Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft)
65800	01	170.72			Paracentesis of anterior chamber of eye (separate procedure); with diagnostic aspiration of aqueous
65805	01	170.72			Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous
65810	03	529.51			Paracentesis of anterior chamber of eye (separate procedure); with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection
65815	02	550.09			Paracentesis of anterior chamber of eye (separate procedure); with removal of blood, with or without irrigation and/or air injection

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
65820		766.84			Goniotomy
65850	04	806.06			Trabeculotomy ab externo
65855		370.31			Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)
65860		302.99			Severing adhesions of anterior segment, laser technique (separate procedure)
65865	01	492.06			Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); goniosynechiae
65870	04	545.74			Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); anterior synechiae, except goniosynechiae
65875	04	568.87			Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); posterior synechiae
65880	04	601.35			Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); corneovitreal adhesions
65900	05	913.11			Removal of epithelial downgrowth, anterior chamber of eye
65920	07	695.13			Removal of implanted material, anterior segment of eye
65930	05	616.96			Removal of blood clot, anterior segment of eye
66020	01	162.26			Injection, anterior chamber of eye (separate procedure); air or liquid
66030	01	142.10			Injection, anterior chamber of eye (separate procedure); medication
66130	07	616.02			Excision of lesion, sclera
66150	04	740.25			Fistulization of sclera for glaucoma; trephination with iridectomy
66155	04	737.05			Fistulization of sclera for glaucoma; thermocauterization with iridectomy
66160	02	846.39			Fistulization of sclera for glaucoma; sclerectomy with punch or scissors, with iridectomy
66165	04	721.25			Fistulization of sclera for glaucoma; iridencleisis or iridotasis
66170	04	1,000.01			Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery
66172	04	1,225.07			Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)
66180	05	1,055.92			Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin)
66185	02	663.52			Revision of aqueous shunt to extraocular reservoir
66220	03	672.33			Repair of scleral staphyloma; without graft
66225	04	824.71			Repair of scleral staphyloma; with graft
66250	02	556.85			Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure
66500	01	359.91			Iridotomy by stab incision (separate procedure); except transfixion
66505	01	386.57			Iridotomy by stab incision (separate procedure); with transfixion as for iris bombe
66600	03	714.84			Iridectomy, with corneoscleral or corneal section; for removal of lesion
66605	03	978.41			Iridectomy, with corneoscleral or corneal section; with cyclectomy
66625	03	496.20			Iridectomy, with corneoscleral or corneal section; peripheral for glaucoma (separate procedure)
66630	03	553.40			Iridectomy, with corneoscleral or corneal section; sector for glaucoma (separate procedure)

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
66635	03	523.91			Iridectomy, with corneoscleral or corneal section; optical (separate procedure)
66680	03	466.87			Repair of iris, ciliary body (as for iridodialysis)
66682	02	555.71			Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (eg, McCannel suture)
66700	02	411.88			Ciliary body destruction; diathermy
66710	02	406.52			Ciliary body destruction; cyclophotocoagulation
66720	02	426.21			Ciliary body destruction; cryotherapy
66740	02	413.26			Ciliary body destruction; cyclodialysis
66761		392.76			Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (one or more sessions)
66762		415.84			Iridoplasty by photocoagulation (one or more sessions) (eg, for improvement of vision, for widening of anterior chamber angle)
66770		457.19			Destruction of cyst or lesion iris or ciliary body (nonexcisional procedure)
66820		451.31			Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife)
66821	02	259.99			Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (one or more stages)
66825	04	746.59			Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)
66830	04	618.99			Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)
66840	04	603.66			Removal of lens material; aspiration technique, one or more stages
66850	07	682.75			Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration
66852	04	735.35			Removal of lens material; pars plana approach, with or without vitrectomy
66920	04	659.54			Removal of lens material; intracapsular
66930	05	759.09			Removal of lens material; intracapsular, for dislocated lens
66940	05	686.63			Removal of lens material; extracapsular (other than 66840, 66850, 66852)
66982	08	946.90			Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage
66983	08	613.49			Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)
66984	08	721.35			Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)
66985	6	642.90			Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
66986	6	868.68			Exchange of intraocular lens
66990		88.13			Use of ophthalmic endoscope (List separately in addition to code for primary procedure)

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
66999		I.C.			Unlisted procedure, anterior segment of eye
67005	04	407.30			Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal
67010	04	476.41			Removal of vitreous, anterior approach (open sky technique or limbal incision); subtotal removal with mechanical vitrectomy
67015	01	596.33			Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)
67025	01	867.31			Injection of vitreous substitute, pars plana or limbal approach, (fluid-gas exchange), with or without aspiration (separate procedure)
67027	04	963.62			Implantation of intravitreal drug delivery system (eg, ganciclovir implant), includes concomitant removal of vitreous
67028		372.93			Intravitreal injection of a pharmacologic agent (separate procedure)
67030	01	476.11			Discission of vitreous strands (without removal), pars plana approach
67031	02	343.23			Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)
67036	04	858.86			Vitrectomy, mechanical, pars plana approach;
67038	05	1,497.42			Vitrectomy, mechanical, pars plana approach; with epiretinal membrane stripping
67039	07	1,096.10			Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation
67040	07	1,264.21			Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation
67101		709.29			Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid
67105		626.36			Repair of retinal detachment, one or more sessions; photocoagulation, with or without drainage of subretinal fluid
67107	05	1,120.27			Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation, and drainage of subretinal fluid
67108	07	1,531.15			Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique
67110		992.35			Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)
67112	07	1,273.68			Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques
67115	02	493.57			Release of encircling material (posterior segment)
67120	02	752.02			Removal of implanted material, posterior segment; extraocular
67121	02	887.77			Removal of implanted material, posterior segment; intraocular
67141	02	508.11			Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy
67145		452.43			Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc)
67208		512.40			Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; cryotherapy, diathermy
67210		608.29			Destruction of localized lesion of retina (eg, macular edema, tumors), one or more

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					sessions; photocoagulation
67218	05	1,312.47			Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; radiation by implantation of source (includes removal of source)
67220		927.77			Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), one or more sessions
67221		354.24			Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)
67225		28.98			Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)
67227	01	526.00			Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; cryotherapy, diathermy
67228		954.20			Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; photocoagulation (laser or xenon arc)
67250	03	776.23			Scleral reinforcement (separate procedure); without graft
67255	03	809.43			Scleral reinforcement (separate procedure); with graft
67299		I.C.			Unlisted procedure, posterior segment
67311	03	530.92			Strabismus surgery, recession or resection procedure; one horizontal muscle
67312	04	652.53			Strabismus surgery, recession or resection procedure; two horizontal muscles
67314	04	600.04			Strabismus surgery, recession or resection procedure; one vertical muscle (excluding superior oblique)
67316	04	724.81			Strabismus surgery, recession or resection procedure; two or more vertical muscles (excluding superior oblique)
67318	04	628.80			Strabismus surgery, any procedure, superior oblique muscle
67320	04	251.83			Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure)
67331	04	239.54			Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)
67332	04	261.11			Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure)
67334	04	231.71			Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)
67335	04	144.71			Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)
67340	04	286.44			Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)
67343		597.00			Release of extensive scar tissue without detaching extraocular muscle (separate procedure)
67345		300.21			Chemodenervation of extraocular muscle
67350	01	191.85			Biopsy of extraocular muscle
67399		I.C.			Unlisted procedure, ocular muscle
67400	03	910.62			Orbitotomy without bone flap (frontal or transconjunctival approach); for

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					exploration, with or without biopsy
67405	04	779.05			Orbitotomy without bone flap (frontal or transconjunctival approach); with drainage only
67412	05	920.15			Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of lesion
67413	05	904.07			Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of foreign body
67414		1,026.93			Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of bone for decompression
67415	01	102.13			Fine needle aspiration of orbital contents
67420	05	1,576.86			Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion
67430	05	1,206.57			Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of foreign body
67440	05	1,165.99			Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with drainage
67445		1,227.64			Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of bone for decompression
67450	05	1,195.98			Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); for exploration, with or without biopsy
67500		65.86			Retrobulbar injection; medication (separate procedure, does not include supply of medication)
67505		71.20			Retrobulbar injection; alcohol
67515		58.17			Injection of medication or other substance into Tenon's capsule
67550	04	919.16			Orbital implant (implant outside muscle cone); insertion
67560	02	935.83			Orbital implant (implant outside muscle cone); removal or revision
67570		1,182.46			Optic nerve decompression (eg, incision or fenestration of optic nerve sheath)
67599		I.C.			Unlisted procedure, orbit
67700		257.03			Blepharotomy, drainage of abscess, eyelid
67710		250.31			Severing of tarsorrhaphy
67715	01	240.87			Canthotomy (separate procedure)
67800		159.52			Excision of chalazion; single
67801		299.00			Excision of chalazion; multiple, same lid
67805		318.44			Excision of chalazion; multiple, different lids
67808	02	369.69			Excision of chalazion; under general anesthesia and/or requiring hospitalization, single or multiple
67810		211.77			Biopsy of eyelid
67820		81.85			Correction of trichiasis; epilation, by forceps only
67825		120.74			Correction of trichiasis; epilation by other than forceps (eg, by electrosurgery, cryotherapy, laser surgery)
67830	02	381.82			Correction of trichiasis; incision of lid margin
67835	02	428.16			Correction of trichiasis; incision of lid margin, with free mucous membrane graft

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
67840		304.19			Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure
67850		321.58			Destruction of lesion of lid margin (up to 1 cm)
67875		350.19			Temporary closure of eyelids by suture (eg, Frost suture)
67880	03	555.83			Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy;
67882	03	662.43			Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy; with transposition of tarsal plate
67900	04	685.84			Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	05	544.37			Repair of blepharoptosis; frontalis muscle technique with suture or other material
67902	05	549.76			Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)
67903	04	729.43			Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	04	771.49			Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	05	654.99			Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	04	572.49			Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
67909	04	606.82			Reduction of overcorrection of ptosis
67911	03	461.36			Correction of lid retraction
67912		1,081.31			Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)
67914	03	536.13			Repair of ectropion; suture
67915		457.73			Repair of ectropion; thermocauterization
67916	04	704.54			Repair of ectropion; excision tarsal wedge
67917	04	644.95			Repair of ectropion; extensive (eg, tarsal strip operations)
67921	03	516.96			Repair of entropion; suture
67922		451.52			Repair of entropion; thermocauterization
67923	04	708.50			Repair of entropion; excision tarsal wedge
67924	04	609.96			Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)
67930		496.99			Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; partial thickness
67935	02	723.55			Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; full thickness
67938		297.17			Removal of embedded foreign body, eyelid
67950	02	577.66			Canthoplasty (reconstruction of canthus)
67961	03	653.46			Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin
67966	03	610.52			Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
67971	03	690.56			Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two-thirds of eyelid, one stage or first stage
67973	03	895.37			Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, one stage or first stage
67974	03	889.07			Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, upper, one stage or first stage
67975	03	650.68			Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; second stage
67999		I.C.			Unlisted procedure, eyelids
68020		293.62			Incision of conjunctiva, drainage of cyst
68040		236.44			Expression of conjunctival follicles (eg, for trachoma)
68100		264.20			Biopsy of conjunctiva
68110		324.60			Excision of lesion, conjunctiva; up to 1 cm
68115	02	326.97			Excision of lesion, conjunctiva; over 1 cm
68130	02	535.57			Excision of lesion, conjunctiva; with adjacent sclera
68135		296.05			Destruction of lesion, conjunctiva
68200		49.43			Subconjunctival injection
68320	04	486.15			Conjunctivoplasty; with conjunctival graft or extensive rearrangement
68325	04	557.33			Conjunctivoplasty; with buccal mucous membrane graft (includes obtaining graft)
68326	04	544.78			Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement
68328	04	618.83			Conjunctivoplasty, reconstruction cul-de-sac; with buccal mucous membrane graft (includes obtaining graft)
68330	04	493.86			Repair of symblepharon; conjunctivoplasty, without graft
68335	04	567.48			Repair of symblepharon; with free graft conjunctiva or buccal mucous membrane (includes obtaining graft)
68340	04	618.44			Repair of symblepharon; division of symblepharon, with or without insertion of conformer or contact lens
68360	02	448.93			Conjunctival flap; bridge or partial (separate procedure)
68362	02	612.34			Conjunctival flap; total (such as Gunderson thin flap or purse string flap)
68371		385.45			Harvesting conjunctival allograft, living donor
68399		I.C.			Unlisted procedure, conjunctiva
68400		386.92			Incision, drainage of lacrimal gland
68420		424.19			Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy)
68440		244.77			Snip incision of lacrimal punctum
68500	03	864.69			Excision of lacrimal gland (dacryoadenectomy), except for tumor; total
68505	03	903.35			Excision of lacrimal gland (dacryoadenectomy), except for tumor; partial
68510	01	535.30			Biopsy of lacrimal gland
68520	03	622.78			Excision of lacrimal sac (dacryocystectomy)
68525	01	258.43			Biopsy of lacrimal sac

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
68530		541.70			Removal of foreign body or dacryolith, lacrimal passages
68540	03	827.74			Excision of lacrimal gland tumor; frontal approach
68550	03	1,018.58			Excision of lacrimal gland tumor; involving osteotomy
68700	02	565.71			Plastic repair of canaliculi
68705		310.42			Correction of everted punctum, cautery
68720	04	699.49			Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)
68745	04	685.36			Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube
68750	04	706.01			Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); with insertion of tube or stent
68760		235.83			Closure of the lacrimal punctum; by thermocauterization, ligation, or laser surgery
68761		197.55			Closure of the lacrimal punctum; by plug, each
68770	04	812.01			Closure of lacrimal fistula (separate procedure)
68801		76.57			Dilation of lacrimal punctum, with or without irrigation
68810	01	172.45			Probing of nasolacrimal duct, with or without irrigation;
68811	02	191.70			Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia
68815	02	469.75			Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent
68840		118.07			Probing of lacrimal canaliculi, with or without irrigation
68850		719.32			Injection of contrast medium for dacryocystography
68899		I.C.			Unlisted procedure, lacrimal system
69000		182.63			Drainage external ear, abscess or hematoma; simple
69005		210.04			Drainage external ear, abscess or hematoma; complicated
69020		224.95			Drainage external auditory canal, abscess
69090		I.C.			Ear piercing
69100		105.39			Biopsy external ear
69105		131.53			Biopsy external auditory canal
69110	01	309.61			Excision external ear; partial, simple repair
69120	02	330.37			Excision external ear; complete amputation
69140	02	602.58			Excision exostosis(es), external auditory canal
69145	02	255.89			Excision soft tissue lesion, external auditory canal
69150	03	961.70			Radical excision external auditory canal lesion; without neck dissection
69155		1,447.79			Radical excision external auditory canal lesion; with neck dissection
69200		129.05			Removal foreign body from external auditory canal; without general anesthesia
69205	01	105.46			Removal foreign body from external auditory canal; with general anesthesia
69210		51.06			Removal impacted cerumen (separate procedure), one or both ears
69220		130.77			Debridement, mastoidectomy cavity, simple (eg, routine cleaning)
69222		215.73			Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning)

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
69300	03	433.37			Otoplasty, protruding ear, with or without size reduction
69310	03	786.86			Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection) (separate procedure)
69320	07	1,190.36			Reconstruction external auditory canal for congenital atresia, single stage
69399		I.C.			Unlisted procedure, external ear
69400		131.62			Eustachian tube inflation, transnasal; with catheterization
69401		80.06			Eustachian tube inflation, transnasal; without catheterization
69405		252.47			Eustachian tube catheterization, transtympanic
69410		99.46			Focal application of phase control substance, middle ear (baffle technique)
69420		183.59			Myringotomy including aspiration and/or eustachian tube inflation
69421	03	158.14			Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia
69424	01	124.36			Ventilating tube removal requiring general anesthesia
69433		191.47			Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia
69436	03	172.59			Tympanostomy (requiring insertion of ventilating tube), general anesthesia
69440	03	569.01			Middle ear exploration through postauricular or ear canal incision
69450	01	435.38			Tympanolysis, transcanal
69501	07	662.65			Transmastoid antrotomy (simple mastoidectomy)
69502	07	887.63			Mastoidectomy; complete
69505	07	923.27			Mastoidectomy; modified radical
69511	07	959.09			Mastoidectomy; radical
69530	07	1,318.63			Petrous apicectomy including radical mastoidectomy
69535		2,397.09			Resection temporal bone, external approach
69540		203.68			Excision aural polyp
69550	05	792.77			Excision aural glomus tumor; transcanal
69552	07	1,326.52			Excision aural glomus tumor; transmastoid
69554		2,212.73			Excision aural glomus tumor; extended (extratemporal)
69601	07	953.78			Revision mastoidectomy; resulting in complete mastoidectomy
69602	07	964.67			Revision mastoidectomy; resulting in modified radical mastoidectomy
69603	07	992.51			Revision mastoidectomy; resulting in radical mastoidectomy
69604	07	990.77			Revision mastoidectomy; resulting in tympanoplasty
69605	07	1,282.48			Revision mastoidectomy; with apicectomy
69610		404.98			Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch
69620	02	494.53			Myringoplasty (surgery confined to drumhead and donor area)
69631	05	727.24			Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction
69632	05	921.87			Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg,

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					postfenestration)
69633	05	881.23			Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis (PORP), total ossicular replacement prosthesis (TORP))
69635	07	928.82			Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction
69636	07	1,081.90			Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction
69637	07	1,074.92			Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis (PORP), total ossicular replacement prosthesis (TORP))
69641	07	909.83			Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction
69642	07	1,186.98			Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction
69643	07	1,085.97			Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction
69644	07	1,190.37			Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction
69645	07	1,152.12			Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction
69646	07	1,255.26			Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction
69650	07	700.43			Stapes mobilization
69660	05	840.81			Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;
69661	05	1,099.33			Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out
69662	05	1,075.32			Revision of stapedectomy or stapedotomy
69666	04	707.20			Repair oval window fistula
69667	04	708.23			Repair round window fistula
69670	03	825.27			Mastoid obliteration (separate procedure)
69676	03	703.88			Tympanic neurectomy
69700	03	577.21			Closure postauricular fistula, mastoid (separate procedure)
69710		I.C.			Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone
69711	01	755.19			Removal or repair of electromagnetic bone conduction hearing device in temporal bone
69714	09	980.68			Implantation, osseointegrated implant, temporal bone, with percutaneous attachment

Code	Group	Fee Global	Fee PC	Fee TC	40.06(8) – Surgical Services Description
					to external speech processor/cochlear stimulator; without mastoidectomy
69715	09	1,256.21			Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
69717	09	1,005.70			Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718	09	1,262.32			Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
69720	05	1,031.44			Decompression facial nerve, intratemporal; lateral to geniculate ganglion
69725	05	1,729.50			Decompression facial nerve, intratemporal; including medial to geniculate ganglion
69740	05	1,078.18			Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion
69745	05	1,142.57			Suture facial nerve, intratemporal, with or without graft or decompression; including medial to geniculate ganglion
69799		I.C.			Unlisted procedure, middle ear
69801	05	631.08			Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); transcanal
69802	07	930.49			Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); with mastoidectomy
69805	07	978.71			Endolymphatic sac operation; without shunt
69806	07	882.71			Endolymphatic sac operation; with shunt
69820	05	743.23			Fenestration semicircular canal
69840	05	700.53			Revision fenestration operation
69905	07	795.60			Labyrinthectomy; transcanal
69910	07	956.02			Labyrinthectomy; with mastoidectomy
69915	07	1,451.71			Vestibular nerve section, translabyrinthine approach
69930	07	1,173.80			Cochlear device implantation, with or without mastoidectomy
69949		I.C.			Unlisted procedure, inner ear
69950		1,746.48			Vestibular nerve section, transcranial approach
69955		1,827.19			Total facial nerve decompression and/or repair (may include graft)
69960		1,824.34			Decompression internal auditory canal
69970		1,987.76			Removal of tumor, temporal bone
69979		I.C.			Unlisted procedure, temporal bone, middle fossa approach
69990		226.74			Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)

Code	Fee Global	Fee PC	Fee TC	40.06(8) Surgical Pathology - Description
80050	I.C.			General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count

				(85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)
80055	I.C.			Obstetric panel This panel must include the following: Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) Antibody, rubella (86762) Syphilis test, qualitative (eg, VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)
80500	23.53			Clinical pathology consultation; limited, without review of patient's history and medical records
80502	78.09			Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records
85060	26.00			Blood smear, peripheral, interpretation by physician with written report
85097	110.42			Bone marrow, smear interpretation
85396	22.32			Coagulation/fibrinolysis assay, whole blood (eg, viscoelastic clot assessment), including use of any pharmacologic additive(s), as indicated, including interpretation and written report, per day
86077	56.04			Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report
86078	57.30			Blood bank physician services; investigation of transfusion reaction including suspicion of transmissible disease, interpretation and written report
86079	57.30			Blood bank physician services; authorization for deviation from standard blood banking procedures (eg, use of outdated blood, transfusion of Rh incompatible units), with written report
86485	I.C.			Skin test; candida
86490	12.82			Skin test; coccidioidomycosis
86510	14.09			Skin test; histoplasmosis
86580	11.56			Skin test; tuberculosis, intradermal
86585	9.15			Skin test; tuberculosis, tine test
86586	I.C.			Skin test; Unlisted antigen, each
86910	I.C.			Blood typing, for paternity testing, per individual; ABO, Rh and MN
86911	I.C.			Blood typing, for paternity testing, per individual; each additional antigen system
88000	I.C.			Necropsy (autopsy), gross examination only; without CNS
88005	I.C.			Necropsy (autopsy), gross examination only; with brain
88007	I.C.			Necropsy (autopsy), gross examination only; with brain and spinal cord
88012	I.C.			Necropsy (autopsy), gross examination only; infant with brain
88014	I.C.			Necropsy (autopsy), gross examination only; stillborn or newborn with brain
88016	I.C.			Necropsy (autopsy), gross examination only; macerated stillborn
88020	I.C.			Necropsy (autopsy), gross and microscopic; without CNS
88025	I.C.			Necropsy (autopsy), gross and microscopic; with brain
88027	I.C.			Necropsy (autopsy), gross and microscopic; with brain and spinal cord
88028	I.C.			Necropsy (autopsy), gross and microscopic; infant with brain
88029	I.C.			Necropsy (autopsy), gross and microscopic; stillborn or newborn with brain
88036	I.C.			Necropsy (autopsy), limited, gross and/or microscopic; regional

88037	I.C.			Necropsy (autopsy), limited, gross and/or microscopic; single organ
88040	I.C.			Necropsy (autopsy); forensic examination
88045	I.C.			Necropsy (autopsy); coroner's call
88099	I.C.			Unlisted necropsy (autopsy) procedure
88104	53.94	32.26	21.68	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation
88106	48.46	32.26	16.20	Cytopathology, fluids, washings or brushings, except cervical or vaginal; filter method only with interpretation
88107	71.77	44.19	27.58	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears and filter preparation with interpretation
88108	56.47	32.26	24.21	Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)
88112	130.37	67.80	62.57	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal
88125	21.36	15.16	6.20	Cytopathology, forensic (eg, sperm)
88141	23.73			Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician (List separately in addition to code for technical service)
88160	58.84	28.73	30.11	Cytopathology, smears, any other source; screening and interpretation
88161	57.15	28.73	28.42	Cytopathology, smears, any other source; preparation, screening and interpretation
88162	59.12	44.19	14.93	Cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains
88172	51.65	34.61	17.04	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)
88173	128.59	79.51	49.08	Cytopathology, evaluation of fine needle aspirate; interpretation and report
88180	74.76	20.62	54.14	Flow cytometry; each cell surface, cytoplasmic or nuclear marker
88182	98.46	44.57	53.89	Flow cytometry; cell cycle or DNA analysis
88199	I.C.	I.C.	I.C.	Unlisted cytopathology procedure
88291	32.01			Cytogenetics and molecular cytogenetics, interpretation and report
88299	I.C.			Unlisted cytogenetic study
88300	15.42	5.00	10.42	Level I - Surgical pathology, gross examination only
88302	34.89	7.73	27.16	Level II - Surgical pathology, gross and microscopic examination Appendix, Incidental Fallopian Tube, Sterilization Fingers/Toes, Amputation, Traumatic Foreskin, Newborn Hernia Sac, Any Location Hydrocele Sac Nerve Skin, Plastic Repair Sympathetic Ganglion Testis, Castration Vaginal Mucosa, Incidental Vas Deferens, Sterilization
88304	45.87	12.81	33.06	Level III - Surgical pathology, gross and microscopic examination Abortion, Induced Abscess Aneurysm - Arterial/Ventricular Anus, Tag Appendix, Other than Incidental Artery, Atheromatous Plaque Bartholin's Gland Cyst Bone Fragment(s), Other than Pathologic Fracture Bursa/Synovial Cyst Carpal Tunnel Tissue Cartilage, Shavings Cholesteatoma Colon, Colostomy Stoma Conjunctiva - Biopsy/Pterygium Cornea Diverticulum - Esophagus/Small Intestine Dupuytren's Contracture Tissue Femoral Head, Other than Fracture Fissure/Fistula Foreskin, Other than Newborn Gallbladder Ganglion Cyst Hematoma Hemorrhoids Hydatid of Morgagni Intervertebral Disc Joint, Loose Body Meniscus Mucocele, Salivary Neuroma - Morton's/Traumatic Pilonidal Cyst/Sinus Polyps, Inflammatory - Nasal/Sinusoidal Skin - Cyst/Tag/Debridement Soft Tissue, Debridement Soft Tissue, Lipoma Spermatocele Tendon/Tendon Sheath Testicular Appendage Thrombus or Embolus Tonsil and/or Adenoids Varicocele Vas Deferens, Other than Sterilization Vein, Varicosity
88305	103.43	43.22	60.21	Level IV - Surgical pathology, gross and microscopic examination Abortion - Spontaneous/Missed Artery, Biopsy Bone Marrow, Biopsy Bone Exostosis Brain/Meninges, Other than for Tumor Resection Breast, Biopsy, Not Requiring Microscopic Evaluation of Surgical Margins Breast, Reduction Mammoplasty Bronchus, Biopsy Cell Block, Any Source

				Cervix, Biopsy Colon, Biopsy Duodenum, Biopsy Endocervix, Curettings/Biopsy Endometrium, Curettings/Biopsy Esophagus, Biopsy Extremity, Amputation, Traumatic Fallopian Tube, Biopsy Fallopian Tube, Ectopic Pregnancy Femoral Head, Fracture Fingers/Toes, Amputation, Non-traumatic Gingiva/Oral Mucosa, Biopsy Heart Valve Joint, Resection Kidney, Biopsy Larynx, Biopsy Leiomyoma(s), Uterine Myomectomy - without Uterus Lip, Biopsy/Wedge Resection Lung, Transbronchial Biopsy Lymph Node, Biopsy Muscle, Biopsy Nasal Mucosa, Biopsy Nasopharynx/Oropharynx, Biopsy Nerve, Biopsy Odontogenic/Dental Cyst Omentum, Biopsy Ovary with or without Tube, Non-neoplastic Ovary, Biopsy/Wedge Resection Parathyroid Gland Peritoneum, Biopsy Pituitary Tumor Placenta, Other than Third Trimester Pleura/Pericardium - Biopsy/Tissue Polyp, Cervical/Endometrial Polyp, Colorectal Polyp, Stomach/Small Intestine Prostate, Needle Biopsy Prostate, TUR Salivary Gland, Biopsy Sinus, Paranasal Biopsy Skin, Other than Cyst/Tag/Debridement/Plastic Repair Small Intestine, Biopsy Soft Tissue, Other than Tumor/Mass/Lipoma/Debridement Spleen Stomach, Biopsy Synovium Testis, Other than Tumor/Biopsy/Castration Thyroglossal Duct/Brachial Cleft Cyst Tongue, Biopsy Tonsil, Biopsy Trachea, Biopsy Ureter, Biopsy Urethra, Biopsy Urinary Bladder, Biopsy Uterus, with or without Tubes and Ovaries, for Prolapse Vagina, Biopsy Vulva/Labia, Biopsy
88307	175.57	91.15	84.42	Level V - Surgical pathology, gross and microscopic examination Adrenal, Resection Bone - Biopsy/Curettings Bone Fragment(s), Pathologic Fracture Brain, Biopsy Brain/Meninges, Tumor Resection Breast, Excision of Lesion, Requiring Microscopic Evaluation of Surgical Margins Breast, Mastectomy - Partial/Simple Cervix, Conization Colon, Segmental Resection, Other than for Tumor Extremity, Amputation, Non-traumatic Eye, Enucleation Kidney, Partial/Total Nephrectomy Larynx, Partial/Total Resection Liver, Biopsy - Needle/Wedge Liver, Partial Resection Lung, Wedge Biopsy Lymph Nodes, Regional Resection Mediastinum, Mass Myocardium, Biopsy Odontogenic Tumor Ovary with or without Tube, Neoplastic Pancreas, Biopsy Placenta, Third Trimester Prostate, Except Radical Resection Salivary Gland Sentinel Lymph Node Small Intestine, Resection, Other than for Tumor Soft Tissue Mass (except Lipoma) - Biopsy/Simple Excision Stomach - Subtotal/Total Resection, Other than for Tumor Testis, Biopsy Thymus, Tumor Thyroid, Total/Lobe Ureter, Resection Urinary Bladder, TUR Uterus, with or without Tubes and Ovaries, Other than Neoplastic/Prolapse
88309	227.78	131.13	96.65	Level VI - Surgical pathology, gross and microscopic examination Bone Resection Breast, Mastectomy - with Regional Lymph Nodes Colon, Segmental Resection for Tumor Colon, Total Resection Esophagus, Partial/Total Resection Extremity, Disarticulation Fetus, with Dissection Larynx, Partial/Total Resection - with Regional Lymph Nodes Lung - Total/Lobe/Segment Resection Pancreas, Total/Subtotal Resection Prostate, Radical Resection Small Intestine, Resection for Tumor Soft Tissue Tumor, Extensive Resection Stomach - Subtotal/Total Resection for Tumor Testis, Tumor Tongue/Tonsil - Resection for Tumor Urinary Bladder, Partial/Total Resection Uterus, with or without Tubes and Ovaries, Neoplastic Vulva, Total/Subtotal Resection
88311	18.08	13.99	4.09	Decalcification procedure (List separately in addition to code for surgical pathology examination)
88312	78.17	31.08	47.09	Special stains (List separately in addition to code for primary service); Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), each
88313	55.60	13.99	41.61	Special stains (List separately in addition to code for primary service); Group II, all other, (eg, iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each
88314	55.69	26.00	29.69	Special stains (List separately in addition to code for primary service); histochemical staining with frozen section(s)
88318	50.16	24.15	26.01	Determinative histochemistry to identify chemical components (eg, copper, zinc)
88319	100.86	30.28	70.58	Determinative histochemistry or cytochemistry to identify enzyme constituents, each
88321	85.09			Consultation and report on referred slides prepared elsewhere
88323	114.01	77.58	36.43	Consultation and report on referred material requiring preparation of slides
88325	208.96			Consultation, comprehensive, with review of records and specimens, with report on referred

				material
88329	52.42			Pathology consultation during surgery;
88331	88.88	68.29	20.59	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen
88332	44.53	33.81	10.72	Pathology consultation during surgery; each additional tissue block with frozen section(s)
88342	90.76	48.85	41.91	Immunohistochemistry (including tissue immunoperoxidase), each antibody
88346	94.93	49.23	45.70	Immunofluorescent study, each antibody; direct method
88347	108.43	48.81	59.62	Immunofluorescent study, each antibody; indirect method
88348	417.88	86.14	331.74	Electron microscopy; diagnostic
88349	452.77	44.19	408.58	Electron microscopy; scanning
88355	183.57	105.89	77.68	Morphometric analysis; skeletal muscle
88356	240.57	171.02	69.55	Morphometric analysis; nerve
88358	99.69	91.27	8.42	Morphometric analysis; tumor (eg, DNA ploidy)
88361	150.32	56.33	93.99	Morphometric analysis; tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative
88362	271.50	123.43	148.07	Nerve teasing preparations
88365	130.03	53.55	76.48	Tissue in situ hybridization, interpretation and report
88380	I.C.	I.C.	I.C.	Microdissection (eg, mechanical, laser capture)
88399	I.C.	I.C.	I.C.	Unlisted surgical pathology procedure
89100	90.67			Duodenal intubation and aspiration; single specimen (eg, simple bile study or afferent loop culture) plus appropriate test procedure
89105	113.88			Duodenal intubation and aspiration; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube
89130	90.92			Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology;
89132	69.85			Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology; after stimulation
89135	98.02			Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); one hour
89136	75.67			Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); two hours
89140	123.48			Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); two hours including gastric stimulation (eg, histalog, pentagastrin)
89141	147.91			Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); three hours, including gastric stimulation
89220	17.46			Sputum, obtaining specimen, aerosol induced technique (separate procedure)
89230	19.15			Sweat collection by iontophoresis
89240	I.C.			Unlisted miscellaneous pathology test

40.06(9) Homemakers

Code	Fee	40.06(9) Homemaker - Description
S5130	3.90	Homemaker service, NOS; per 15 minutes

40.06(10) Medicine / Podiatric Care

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
90281	I.C.			Immune globulin (Ig), human, for intramuscular use
90283	I.C.			Immune globulin (IgIV), human, for intravenous use
90287	I.C.			Botulinum antitoxin, equine, any route
90288	I.C.			Botulism immune globulin, human, for intravenous use
90291	I.C.			Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use
90296	I.C.			Diphtheria antitoxin, equine, any route
90371	I.C.			Hepatitis B immune globulin (HBIg), human, for intramuscular use
90375	I.C.			Rabies immune globulin (RIg), human, for intramuscular and/or subcutaneous use
90376	I.C.			Rabies immune globulin, heat-treated (RIg-HT), human, for intramuscular and/or subcutaneous use
90378	I.C.			Respiratory syncytial virus immune globulin (RSV-IgIM), for intramuscular use, 50 mg, each
90379	I.C.			Respiratory syncytial virus immune globulin (RSV-IgIV), human, for intravenous use
90384	I.C.			Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use
90385	I.C.			Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use
90386	I.C.			Rho(D) immune globulin (RhIgIV), human, for intravenous use
90389	I.C.			Tetanus immune globulin (TIg), human, for intramuscular use
90393	I.C.			Vaccinia immune globulin, human, for intramuscular use
90396	I.C.			Varicella-zoster immune globulin, human, for intramuscular use
90399	I.C.			Unlisted immune globulin
90471	9.15			Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid)
90472	6.20			Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90473	I.C.			Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90474	I.C.			Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90476	I.C.			Adenovirus vaccine, type 4, live, for oral use
90477	I.C.			Adenovirus vaccine, type 7, live, for oral use
90581	I.C.			Anthrax vaccine, for subcutaneous use
90585	I.C.			Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586	I.C.			Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632	I.C.			Hepatitis A vaccine, adult dosage, for intramuscular use
90633	I.C.			Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90634	I.C.			Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
90636	I.C.			Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90645	I.C.			Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
90646	I.C.			Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647	I.C.			Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648	I.C.			Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
90655	I.C.			Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90657	I.C.			Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use
90658	I.C.			Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90660	I.C.			Influenza virus vaccine, live, for intranasal use
90665	I.C.			Lyme disease vaccine, adult dosage, for intramuscular use
90669	I.C.			Pneumococcal conjugate vaccine, polyvalent, for children under five years, for intramuscular use
90675	I.C.			Rabies vaccine, for intramuscular use
90676	I.C.			Rabies vaccine, for intradermal use
90680	I.C.			Rotavirus vaccine, tetravalent, live, for oral use
90690	I.C.			Typhoid vaccine, live, oral
90691	I.C.			Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use
90692	I.C.			Typhoid vaccine, heat- and phenol-inactivated (H-P), for subcutaneous or intradermal use
90693	I.C.			Typhoid vaccine, acetone-killed, dried (AKD), for subcutaneous use (U.S. military)
90698	I.C.			Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP - Hib - IPV), for intramuscular use
90700	I.C.			Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for use in individuals younger than seven years, for intramuscular use
90701	I.C.			Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use
90702	I.C.			Diphtheria and tetanus toxoids (DT) adsorbed for use in individuals younger than seven years, for intramuscular use
90703	I.C.			Tetanus toxoid adsorbed, for intramuscular use
90704	I.C.			Mumps virus vaccine, live, for subcutaneous use
90705	I.C.			Measles virus vaccine, live, for subcutaneous use
90706	I.C.			Rubella virus vaccine, live, for subcutaneous use
90707	I.C.			Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90708	I.C.			Measles and rubella virus vaccine, live, for subcutaneous use
90710	I.C.			Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90712	I.C.			Poliovirus vaccine, (any type(s)) (OPV), live, for oral use
90713	I.C.			Poliovirus vaccine, inactivated, (IPV), for subcutaneous use

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
90715	I.C.			Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP), for use in individuals seven years or older, for intramuscular use
90716	I.C.			Varicella virus vaccine, live, for subcutaneous use
90717	I.C.			Yellow fever vaccine, live, for subcutaneous use
90718	I.C.			Tetanus and diphtheria toxoids (Td) adsorbed for use in individuals seven years or older, for intramuscular use
90719	I.C.			Diphtheria toxoid, for intramuscular use
90720	I.C.			Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
90721	I.C.			Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use
90723	I.C.			Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use
90725	I.C.			Cholera vaccine for injectable use
90727	I.C.			Plague vaccine, for intramuscular use
90732	I.C.			Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
90733	I.C.			Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use
90734	I.C.			Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90735	I.C.			Japanese encephalitis virus vaccine, for subcutaneous use
90740	I.C.			Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
90743	I.C.			Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
90744	I.C.			Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use
90746	I.C.			Hepatitis B vaccine, adult dosage, for intramuscular use
90747	I.C.			Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
90748	I.C.			Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use
90749	I.C.			Unlisted vaccine/toxoid
90780	99.14			Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour
90781	27.00			Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)
90782	20.20			Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular
90783	20.50			Therapeutic, prophylactic or diagnostic injection (specify material injected); intra-arterial
90784	41.33			Therapeutic, prophylactic or diagnostic injection (specify material injected); intravenous
90788	18.09			Intramuscular injection of antibiotic (specify)
90799	I.C.			Unlisted therapeutic, prophylactic or diagnostic injection
90801	157.01			Psychiatric diagnostic interview examination
90802	166.49			Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
90804	67.48			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;
90805	73.94			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90806	101.15			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;
90807	107.48			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90808	151.03			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;
90809	155.80			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
90810	72.05			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;
90811	81.04			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90812	109.39			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;
90813	114.58			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90814	158.55			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;
90815	162.06			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
90816	67.73			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;
90817	73.34			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90818	101.86			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;
90819	106.51			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90821	151.40			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
90822	155.20			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
90823	72.72			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;
90824	79.18			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90826	108.07			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;
90827	112.34			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90828	158.37			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;
90829	161.03			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
90845	93.45			Psychoanalysis
90846	97.91			Family psychotherapy (without the patient present)
90847	119.71			Family psychotherapy (conjoint psychotherapy) (with patient present)
90849	33.93			Multiple-family group psychotherapy
90853	33.09			Group psychotherapy (other than of a multiple-family group)
90857	37.00			Interactive group psychotherapy
90862	53.29			Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
90865	176.52			Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital (Amytal) interview)
90870	105.70			Electroconvulsive therapy (includes necessary monitoring); single seizure
90871	149.78			Electroconvulsive therapy (includes necessary monitoring); multiple seizures, per day
90875	84.39			Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes
90876	122.05			Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes
90880	128.23			Hypnotherapy
90882	I.C.			Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
90885	52.78			Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes
90887	91.58			Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
90889	I.C.			Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers
90899	I.C.			Unlisted psychiatric service or procedure
90901	43.88			Biofeedback training by any modality
90911	102.93			Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry
90918	741.06			End stage renal disease (ESRD) related services per full month; for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90919	501.93			End stage renal disease (ESRD) related services per full month; for patients between two and eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90920	441.28			End stage renal disease (ESRD) related services per full month; for patients between twelve and nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90921	276.93			End stage renal disease (ESRD) related services per full month; for patients twenty years of age and over
90922	23.53			End stage renal disease (ESRD) related services (less than full month), per day; for patients under two years of age
90923	16.34			End stage renal disease (ESRD) related services (less than full month), per day; for patients between two and eleven years of age
90924	14.41			End stage renal disease (ESRD) related services (less than full month), per day; for patients between twelve and nineteen years of age
90925	9.33			End stage renal disease (ESRD) related services (less than full month), per day; for patients twenty years of age and over
90935	75.45			Hemodialysis procedure with single physician evaluation
90937	122.98			Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription
90939	I.C.			Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method, hook-up; transcutaneous measurement and disconnection
90940	I.C.			Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method, hook-up; measurement and disconnection
90945	79.28			Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single physician evaluation
90947	126.13			Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated physician evaluations, with or without substantial revision of dialysis prescription
90989	I.C.			Dialysis training, patient, including helper where applicable, any mode, completed course
90993	I.C.			Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
90997	130.62			Hemoperfusion (eg, with activated charcoal or resin)
90999	I.C.			Unlisted dialysis procedure, inpatient or outpatient
91000	42.94	39.27	3.67	Esophageal intubation and collection of washings for cytology, including preparation of specimens (separate procedure)
91010	164.97	67.06	97.91	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study;
91011	195.06	80.71	114.35	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study; with mecholyl or similar stimulant
91012	200.04	78.65	121.39	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study; with acid perfusion studies
91020	181.72	76.64	105.08	Gastric motility (manometric) studies
91030	137.29	49.43	87.86	Esophagus, acid perfusion (Bernstein) test for esophagitis
91032	222.06	64.71	157.35	Esophagus, acid reflux test, with intraluminal pH electrode for detection of gastroesophageal reflux;
91033	229.48	69.79	159.69	Esophagus, acid reflux test, with intraluminal pH electrode for detection of gastroesophageal reflux; prolonged recording
91052	123.90	42.79	81.11	Gastric analysis test with injection of stimulant of gastric secretion (eg, histamine, insulin, pentagastrin, calcium and secretin)
91055	137.45	48.33	89.12	Gastric intubation, washings, and preparing slides for cytology (separate procedure)
91060	30.81	23.47	7.34	Gastric saline load test
91065	91.06	10.79	80.27	Breath hydrogen test (eg, for detection of lactase deficiency)
91100	55.05			Intestinal bleeding tube, passage, positioning and monitoring
91105	18.35			Gastric intubation, and aspiration or lavage for treatment (eg, for ingested poisons)
91110	1,030.68	192.67	838.01	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report
91122	328.20	95.64	232.56	Anorectal manometry
91123	I.C.			Pulsed irrigation of fecal impaction
91132		28.82		Electrogastrography, diagnostic, transcutaneous;
91133		36.21		Electrogastrography, diagnostic, transcutaneous; with provocative testing
91299	I.C.	I.C.	I.C.	Unlisted diagnostic gastroenterology procedure
92002	74.25			Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	134.99			Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits
92012	68.56			Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	100.25			Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits
92015	77.44			Determination of refractive state
92018	141.00			Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete
92019	74.21			Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; limited

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
92020	28.16			Gonioscopy (separate procedure)
92060	56.97	38.54	18.43	Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)
92065	37.32	20.58	16.74	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation
92070	72.22			Fitting of contact lens for treatment of disease, including supply of lens
92081	50.01	20.20	29.81	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
92082	65.67	24.90	40.77	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92083	75.52	28.43	47.09	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
92100	88.41			Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)
92120	74.99			Tonography with interpretation and report, recording indentation tonometer method or perilimbal suction method
92130	82.99			Tonography with water provocation
92135	46.68	20.24	26.44	Scanning computerized ophthalmic diagnostic imaging (eg, scanning laser) with interpretation and report, unilateral
92136	96.53	31.20	65.33	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation
92140	58.78			Provocative tests for glaucoma, with interpretation and report, without tonography
92225	23.90			Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial
92226	21.60			Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent
92230	93.62			Fluorescein angioscopy with interpretation and report
92235	156.45	46.74	109.71	Fluorescein angiography (includes multiframe imaging) with interpretation and report
92240	340.23	62.74	277.49	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report
92250	90.12	25.32	64.80	Fundus photography with interpretation and report
92260	20.07			Ophthalmodynamometry
92265	111.00	42.95	68.05	Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report
92270	98.11	46.08	52.03	Electro-oculography with interpretation and report
92275	120.64	56.39	64.25	Electroretinography with interpretation and report
92283	42.00	9.66	32.34	Color vision examination, extended, eg, anomaloscope or equivalent
92284	107.02	13.14	93.88	Dark adaptation examination with interpretation and report
92285	53.25	11.64	41.61	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
				photography)
92286	167.85	37.84	130.01	Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count
92287	144.54			Special anterior segment photography with interpretation and report; with fluorescein angiography
92310	92.53			Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia
92311	91.67			Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye
92312	97.61			Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes
92313	84.19			Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens
92314	65.94			Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia
92315	57.32			Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, one eye
92316	68.10			Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, both eyes
92317	61.53			Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneoscleral lens
92325	16.74			Modification of contact lens (separate procedure), with medical supervision of adaptation
92326	70.93			Replacement of contact lens
92330	87.75			Prescription, fitting, and supply of ocular prosthesis (artificial eye), with medical supervision of adaptation
92335	59.85			Prescription of ocular prosthesis (artificial eye) and direction of fitting and supply by independent technician, with medical supervision of adaptation
92340	43.76			Fitting of spectacles, except for aphakia; monofocal
92341	49.22			Fitting of spectacles, except for aphakia; bifocal
92342	52.32			Fitting of spectacles, except for aphakia; multifocal, other than bifocal
92352	45.03			Fitting of spectacle prosthesis for aphakia; monofocal
92353	52.34			Fitting of spectacle prosthesis for aphakia; multifocal
92354	377.75			Fitting of spectacle mounted low vision aid; single element system
92355	183.25			Fitting of spectacle mounted low vision aid; telescopic or other compound lens system
92358	42.39			Prosthesis service for aphakia, temporary (disposable or loan, including materials)
92370	35.85			Repair and refitting spectacles; except for aphakia
92371	26.74			Repair and refitting spectacles; spectacle prosthesis for aphakia
92390	I.C.			Supply of spectacles, except prosthesis for aphakia and low vision aids
92391	I.C.			Supply of contact lenses, except prosthesis for aphakia
92392	160.36			Supply of low vision aids (A low vision aid is any lens or device used to aid or improve

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
				visual function in a person whose vision cannot be normalized by conventional spectacle correction. Includes reading additions up to 4D.)
92393	512.82			Supply of ocular prosthesis (artificial eye)
92395	56.96			Supply of permanent prosthesis for aphakia; spectacles
92396	93.15			Supply of permanent prosthesis for aphakia; contact lenses
92499	I.C.	I.C.	I.C.	Unlisted ophthalmological service or procedure
92502	106.68			Otolaryngologic examination under general anesthesia
92504	27.74			Binocular microscopy (separate diagnostic procedure)
92510	146.35			Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming
92531	I.C.			Spontaneous nystagmus, including gaze
92532	I.C.			Positional nystagmus test
92533	I.C.			Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)
92534	I.C.			Optokinetic nystagmus test
92541	57.17	23.69	33.48	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	58.03	19.49	38.54	Positional nystagmus test, minimum of 4 positions, with recording
92543	26.71	6.18	20.53	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording
92544	46.11	15.16	30.95	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
92545	42.87	13.61	29.26	Oscillating tracking test, with recording
92546	87.72	16.72	71.00	Sinusoidal vertical axis rotational testing
92547	50.28			Use of vertical electrodes (List separately in addition to code for primary procedure)
92548	157.83	30.42	127.41	Computerized dynamic posturography
92551	I.C.			Screening test, pure tone, air only
92552	19.75			Pure tone audiometry (threshold); air only
92553	29.62			Pure tone audiometry (threshold); air and bone
92555	16.80			Speech audiometry threshold;
92556	25.83			Speech audiometry threshold; with speech recognition
92557	53.76			Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92559	I.C.			Audiometric testing of groups
92560	I.C.			Bekesy audiometry; screening
92561	32.15			Bekesy audiometry; diagnostic
92562	18.06			Loudness balance test, alternate binaural or monaural
92563	16.80			Tone decay test
92564	21.31			Short increment sensitivity index (SISI)
92565	17.64			Stenger test, pure tone
92567	23.72			Tympanometry (impedance testing)

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
92568	16.80			Acoustic reflex testing
92569	18.06			Acoustic reflex decay test
92571	17.22			Filtered speech test
92572	4.09			Staggered spondaic word test
92573	15.95			Lombard test
92575	13.25			Sensorineural acuity level test
92576	20.05			Synthetic sentence identification test
92577	32.45			Stenger test, speech
92579	32.57			Visual reinforcement audiometry (VRA)
92582	32.57			Conditioning play audiometry
92583	39.92			Select picture audiometry
92584	111.26			Electrocochleography
92585	111.33	28.73	82.60	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92586	82.60			Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited
92587	66.67	8.15	58.52	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
92588	86.90	21.04	65.86	Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)
92589	24.14			Central auditory function test(s) (specify)
92590	I.C.			Hearing aid examination and selection; monaural
92591	I.C.			Hearing aid examination and selection; binaural
92592	I.C.			Hearing aid check; monaural
92593	I.C.			Hearing aid check; binaural
92594	I.C.			Electroacoustic evaluation for hearing aid; monaural
92595	I.C.			Electroacoustic evaluation for hearing aid; binaural
92596	26.67			Ear protector attenuation measurements
92597	105.17			Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
92601	145.84			Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming
92602	101.58			Diagnostic analysis of cochlear implant, patient under 7 years of age; subsequent reprogramming
92603	96.10			Diagnostic analysis of cochlear implant, age 7 years or older; with programming
92604	64.07			Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming
92605	I.C.			Evaluation for prescription of non-speech-generating augmentative and alternative communication device
92606	I.C.			Therapeutic service(s) for the use of non-speech-generating device, including programming and modification
92607	137.23			Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	29.74			Evaluation for prescription for speech-generating augmentative and alternative

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
				communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)
92609	68.65			Therapeutic services for the use of speech-generating device, including programming and modification
92610	147.41			Evaluation of oral and pharyngeal swallowing function
92611	147.41			Motion fluoroscopic evaluation of swallowing function by cine or video recording
92612	164.53			Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording;
92613	44.71			Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; physician interpretation and report only
92614	151.88			Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;
92615	40.43			Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; physician interpretation and report only
92616	211.98			Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;
92617	49.84			Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; physician interpretation and report only
92700	I.C.			Unlisted otorhinolaryngological service or procedure
92950	191.73			Cardiopulmonary resuscitation (eg, in cardiac arrest)
92953	18.67			Temporary transcutaneous pacing
92960	368.59			Cardioversion, elective, electrical conversion of arrhythmia; external
92961	267.49			Cardioversion, elective, electrical conversion of arrhythmia; internal (separate procedure)
92970	183.77			Cardioassist-method of circulatory assist; internal
92971	104.68			Cardioassist-method of circulatory assist; external
92973	182.27			Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure)
92974	167.97			Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure)
92975	399.57			Thrombolysis, coronary; by intracoronary infusion, including selective coronary angiography
92977	354.40			Thrombolysis, coronary; by intravenous infusion
92978	300.17	99.91	200.26	Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)
92979	180.26	79.41	100.85	Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)
92980	840.53			Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel
92981	233.20			Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)
92982	624.00			Percutaneous transluminal coronary balloon angioplasty; single vessel
92984	166.00			Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
92986	1,351.87			Percutaneous balloon valvuloplasty; aortic valve
92987	1,403.75			Percutaneous balloon valvuloplasty; mitral valve
92990	1,091.40			Percutaneous balloon valvuloplasty; pulmonary valve
92992	I.C.			Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)
92993	I.C.			Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)
92995	686.08			Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel
92996	182.59			Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)
92997	679.01			Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel
92998	330.14			Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)
93000	28.81			Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005	19.57			Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report
93010	9.24			Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
93012	260.01			Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24-hour attended monitoring, per 30 day period of time; tracing only
93014	28.22			Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24-hour attended monitoring, per 30 day period of time; physician review with interpretation and report only
93015	115.65			Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
93016	24.44			Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report
93017	74.54			Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report
93018	16.67			Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only
93024	114.20	64.59	49.61	Ergonovine provocation test
93025	377.00	41.11	335.89	Microvolt T-wave alternans for assessment of ventricular arrhythmias
93040	15.06			Rhythm ECG, one to three leads; with interpretation and report
93041	6.62			Rhythm ECG, one to three leads; tracing only without interpretation and report
93042	8.44			Rhythm ECG, one to three leads; interpretation and report only
93224	179.82			Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation
93225	54.67			Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; recording (includes hook-up, recording, and disconnection)

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
93226	96.51			Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; scanning analysis with report
93227	28.64			Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; physician review and interpretation
93230	191.81			Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation
93231	67.37			Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; recording (includes hook-up, recording, and disconnection)
93232	95.79			Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; microprocessor-based analysis with report
93233	28.64			Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; physician review and interpretation
93235	139.08			Electrocardiographic monitoring for 24 hours by continuous computerized monitoring and non-continuous recording, and real-time data analysis utilizing a device capable of producing intermittent full-sized waveform tracings, possibly patient activated; includes monitoring and real-time data analysis with report, physician review and interpretation
93236	114.64			Electrocardiographic monitoring for 24 hours by continuous computerized monitoring and non-continuous recording, and real-time data analysis utilizing a device capable of producing intermittent full-sized waveform tracings, possibly patient activated; monitoring and real-time data analysis with report
93237	24.44			Electrocardiographic monitoring for 24 hours by continuous computerized monitoring and non-continuous recording, and real-time data analysis utilizing a device capable of producing intermittent full-sized waveform tracings, possibly patient activated; physician review and interpretation
93268	342.89			Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission, physician review and interpretation
93270	54.67			Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; recording (includes hook-up, recording, and disconnection)
93271	260.01			Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; monitoring, receipt of transmissions, and analysis
93272	28.22			Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; physician review and interpretation only
93278	65.72	13.94	51.78	Signal-averaged electrocardiography (SAECG), with or without ECG
93303	240.79	70.76	170.03	Transthoracic echocardiography for congenital cardiac anomalies; complete
93304	126.79	40.69	86.10	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study
93307	221.10	51.07	170.03	Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
93308	115.54	29.44	86.10	Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study
93312	287.72	119.26	168.46	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
93313	I.C.			Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only
93314	236.91	68.45	168.46	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only
93315		151.43		Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
93316	47.74			Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only
93317		99.35		Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only
93318		104.87		Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
93320	97.05	20.95	76.10	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete
93321	58.10	8.49	49.61	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)
93325	133.16	4.20	128.96	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)
93350	158.95	80.44	78.51	Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report
93501	914.47	168.06	746.41	Right heart catheterization
93503	144.10			Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes
93505	333.11	244.43	88.68	Endomyocardial biopsy
93508	802.14	249.83	552.31	Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization
93510	1,894.93	262.90	1,632.03	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous
93511	1,890.50	301.88	1,588.62	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; by cutdown
93514	1,999.96	411.34	1,588.62	Left heart catheterization by left ventricular puncture
93524	2,485.33	409.08	2,076.25	Combined transseptal and retrograde left heart catheterization
93526	2,488.80	355.48	2,133.32	Combined right heart catheterization and retrograde left heart catheterization
93527	2,504.57	428.32	2,076.25	Combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)
93528	2,603.08	526.83	2,076.25	Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)
93529	2,362.41	286.16	2,076.25	Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
93530	996.02	249.61	746.41	Right heart catheterization, for congenital cardiac anomalies
93531	2,615.65	482.33	2,133.32	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies
93532	2,651.87	575.62	2,076.25	Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies
93533	2,462.58	386.33	2,076.25	Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies
93539	22.13			Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass
93540	23.68			Injection procedure during cardiac catheterization; for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries
93541	15.87			Injection procedure during cardiac catheterization; for pulmonary angiography
93542	15.87			Injection procedure during cardiac catheterization; for selective right ventricular or right atrial angiography
93543	16.29			Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography
93544	13.94			Injection procedure during cardiac catheterization; for aortography
93545	22.13			Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)
93555	320.99	45.23	275.76	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography
93556	480.29	46.41	433.88	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)
93561	49.92	26.20	23.72	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)
93562	23.13	8.44	14.69	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output
93571	300.70	100.44	200.26	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)
93572	182.53	81.68	100.85	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)
93580	1,022.67			Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant
93581	1,368.05			Percutaneous transcatheter closure of a congenital ventricular septal defect with implant
93600	205.35	118.83	86.52	Bundle of His recording
93602	168.44	119.13	49.31	Intra-atrial recording
93603	192.95	118.41	74.54	Right ventricular recording
93609	409.03	289.27	119.76	Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
93610	229.41	169.08	60.33	Intra-atrial pacing
93612	240.67	169.08	71.59	Intraventricular pacing
93613	398.83			Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)
93615	64.00	49.91	14.09	Esophageal recording of atrial electrogram with or without ventricular electrogram(s);
93616	90.08	75.99	14.09	Esophageal recording of atrial electrogram with or without ventricular electrogram(s); with pacing
93618	414.15	239.18	174.97	Induction of arrhythmia by electrical pacing
93619	764.71	424.35	340.36	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia
93620		662.77		Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording
93621		119.16		Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)
93622		192.20		Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording (List separately in addition to code for primary procedure)
93623		160.08		Programmed stimulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure)
93624	370.52	282.74	87.78	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia
93631	706.08	427.40	278.68	Intra-operative epicardial and endocardial pacing and mapping to localize the site of tachycardia or zone of slow conduction for surgical correction
93640	512.39	196.29	316.10	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement;
93641	648.24	332.14	316.10	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator
93642	599.41	283.31	316.10	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)
93650	602.96			Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement
93651	910.60			Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination
93652	990.16			Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
				tachycardia
93660	176.41	104.57	71.84	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention
93662		167.07		Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)
93668	I.C.			Peripheral arterial disease (PAD) rehabilitation, per session
93701	50.01	9.66	40.35	Bioimpedance, thoracic, electrical
93720	40.55			Plethysmography, total body; with interpretation and report
93721	31.73			Plethysmography, total body; tracing only, without interpretation and report
93722	8.82			Plethysmography, total body; interpretation and report only
93724	446.53	271.56	174.97	Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)
93727	29.84			Electronic analysis of implantable loop recorder (ILR) system (includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)
93731	47.01	25.16	21.85	Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming
93732	73.77	51.07	22.70	Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); with reprogramming
93733	42.23	9.66	32.57	Electronic analysis of dual chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker), telephonic analysis
93734	36.30	20.95	15.35	Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming
93735	61.08	41.33	19.75	Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); with reprogramming
93736	36.85	8.49	28.36	Electronic analysis of single chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker), telephonic analysis
93740	15.06	8.02	7.04	Temperature gradient studies
93741	73.70	44.26	29.44	Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber, without reprogramming
93742	79.53	50.09	29.44	Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation

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				of recordings at rest and during exercise, analysis of event markers and device response); single chamber, with reprogramming
93743	89.29	56.90	32.39	Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); dual chamber, without reprogramming
93744	94.53	65.09	29.44	Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); dual chamber, with reprogramming
93760	I.C.			Thermogram; cephalic
93762	I.C.			Thermogram; peripheral
93770	10.00	8.44	1.56	Determination of venous pressure
93784	80.57			Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report
93786	38.66			Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only
93788	21.80			Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report
93790	20.11			Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report
93797	22.68			Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798	31.51			Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)
93799	I.C.	I.C.	I.C.	Unlisted cardiovascular service or procedure
93875	81.87	11.97	69.90	Non-invasive physiologic studies of extracranial arteries, complete bilateral study (eg, periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)
93880	210.82	32.98	177.84	Duplex scan of extracranial arteries; complete bilateral study
93882	150.06	22.48	127.58	Duplex scan of extracranial arteries; unilateral or limited study
93886	237.36	52.84	184.52	Transcranial Doppler study of the intracranial arteries; complete study
93888	160.28	34.58	125.70	Transcranial Doppler study of the intracranial arteries; limited study
93922	95.28	13.82	81.46	Non-invasive physiologic studies of upper or lower extremity arteries, single level, bilateral (eg, ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)
93923	151.52	24.79	126.73	Non-invasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (eg, segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia)
93924	186.65	27.82	158.83	Non-invasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study
93925	239.15	31.80	207.35	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
93926	169.92	21.39	148.53	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study

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93930	191.93	25.29	166.64	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study
93931	138.36	16.93	121.43	Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study
93965	95.81	18.86	76.95	Non-invasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)
93970	206.79	37.14	169.65	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
93971	146.82	24.49	122.33	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study
93975	330.01	97.07	232.94	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
93976	202.58	64.59	137.99	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study
93978	188.31	35.58	152.73	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
93979	136.99	24.41	112.58	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study
93980	261.23	66.82	194.41	Duplex scan of arterial inflow and venous outflow of penile vessels; complete study
93981	220.82	23.52	197.30	Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study
93990	161.09	13.82	147.27	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)
94010	35.56	8.82	26.74	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
94014	52.97			Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation
94015	25.59			Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)
94016	27.38			Patient-initiated spirometric recording per 30-day period of time; physician review and interpretation only
94060	61.01	16.21	44.80	Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral)
94070	152.27	31.24	121.03	Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after antigen, cold air, methacholine or other chemical agent, with subsequent spirometrics
94150	23.47	4.20	19.27	Vital capacity, total (separate procedure)
94200	23.59	5.71	17.88	Maximum breathing capacity, maximal voluntary ventilation
94240	41.11	13.48	27.63	Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method
94250	32.15	5.71	26.44	Expired gas collection, quantitative, single procedure (separate procedure)
94260	30.43	6.89	23.54	Thoracic gas volume
94350	42.92	13.48	29.44	Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time
94360	40.99	13.48	27.51	Determination of resistance to airflow, oscillatory or plethysmographic methods
94370	41.06	13.48	27.58	Determination of airway closing volume, single breath tests

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94375	38.31	16.21	22.10	Respiratory flow volume loop
94400	52.59	20.44	32.15	Breathing response to CO2 (CO2 response curve)
94450	44.95	20.74	24.21	Breathing response to hypoxia (hypoxia response curve)
94620	129.75	33.17	96.58	Pulmonary stress testing; simple (eg, prolonged exercise test for bronchospasm with pre- and post-spirometry)
94621	145.18	73.47	71.71	Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)
94640	14.09			Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device)
94642	I.C.			Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis
94656	97.85			Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day
94657	74.65			Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; subsequent days
94660	57.68			Continuous positive airway pressure ventilation (CPAP), initiation and management
94662	39.38			Continuous negative pressure ventilation (CNP), initiation and management
94664	14.69			Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
94667	24.26			Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation
94668	19.99			Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent
94680	91.58	13.48	78.10	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple
94681	121.88	10.79	111.09	Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted
94690	87.18	3.78	83.40	Oxygen uptake, expired gas analysis; rest, indirect (separate procedure)
94720	54.06	13.48	40.58	Carbon monoxide diffusing capacity (eg, single breath, steady state)
94725	136.79	13.48	123.31	Membrane diffusion capacity
94750	67.08	11.92	55.16	Pulmonary compliance study (eg, plethysmography, volume and pressure measurements)
94760	2.29			Noninvasive ear or pulse oximetry for oxygen saturation; single determination
94761	4.75			Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)
94762	19.86			Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)
94770	78.45	7.64	70.81	Carbon dioxide, expired gas determination by infrared analyzer
94772	I.C.	I.C.	I.C.	Circadian respiratory pattern recording (pediatric pneumogram), 12 to 24 hour continuous recording, infant
94799	I.C.	I.C.	I.C.	Unlisted pulmonary service or procedure
95004	4.52			Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests
95010	19.87			Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, specify number of tests
95015	12.28			Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, specify number of tests
95024	6.62			Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction,

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				specify number of tests
95027	6.62			Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, specify number of tests
95028	10.42			Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests
95044	9.15			Patch or application test(s) (specify number of tests)
95052	11.26			Photo patch test(s) (specify number of tests)
95056	7.89			Photo tests
95060	15.35			Ophthalmic mucous membrane tests
95065	9.15			Direct nasal mucous membrane test
95070	97.13			Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similar compounds
95071	124.11			Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with antigens or gases, specify
95075	72.01			Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)
95078	11.56			Provocative testing (eg, Rinkel test)
95115	16.62			Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
95117	21.68			Professional services for allergen immunotherapy not including provision of allergenic extracts; two or more injections
95120	I.C.			Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; single injection
95125	I.C.			Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; two or more injections
95130	I.C.			Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; single stinging insect venom
95131	I.C.			Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; two stinging insect venoms
95132	I.C.			Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; three stinging insect venoms
95133	I.C.			Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; four stinging insect venoms
95134	I.C.			Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; five stinging insect venoms
95144	8.89			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single dose vial(s) (specify number of vials)
95145	16.47			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom
95146	21.11			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); two single stinging insect venoms
95147	20.27			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); three single stinging insect venoms
95148	27.01			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); four single stinging insect venoms
95149	36.71			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); five single stinging insect venoms

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95165	10.99			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)
95170	8.46			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses)
95180	141.37			Rapid desensitization procedure, each hour (eg, insulin, penicillin, equine serum)
95199	I.C.			Unlisted allergy/clinical immunologic service or procedure
95250	161.33			Glucose monitoring for up to 72 hours by continuous recording and storage of glucose values from interstitial tissue fluid via a subcutaneous sensor (includes hook-up, calibration, patient initiation and training, recording, disconnection, downloading with printout of data)
95805	768.62	100.82	667.80	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness
95806	234.60	87.04	147.56	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist
95807	568.93	86.74	482.19	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist
95808	660.03	142.43	517.60	Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist
95810	866.99	186.68	680.31	Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811	938.36	201.26	737.10	Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist
95812	210.35	61.20	149.15	Electroencephalogram (EEG) extended monitoring; 41-60 minutes
95813	278.46	96.85	181.61	Electroencephalogram (EEG) extended monitoring; greater than one hour
95816	177.59	61.62	115.97	Electroencephalogram (EEG); including recording awake and drowsy
95819	200.78	61.62	139.16	Electroencephalogram (EEG); including recording awake and asleep
95822	229.50	61.20	168.30	Electroencephalogram (EEG); recording in coma or sleep only
95824		43.19		Electroencephalogram (EEG); cerebral death evaluation only
95827	159.94	58.79	101.15	Electroencephalogram (EEG); all night recording
95829	1,564.92	343.12	1,221.80	Electrocorticogram at surgery (separate procedure)
95830	208.57			Insertion by physician of sphenoidal electrodes for electroencephalographic (EEG) recording
95831	25.19			Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk
95832	21.77			Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side
95833	36.99			Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands
95834	44.30			Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands
95851	21.93			Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)
95852	15.41			Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side

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95857	46.30			Tensilon test for myasthenia gravis;
95858	106.21	88.57	17.64	Tensilon test for myasthenia gravis; with electromyographic recording
95860	99.13	55.11	44.02	Needle electromyography; one extremity with or without related paraspinal areas
95861	121.53	88.54	32.99	Needle electromyography; two extremities with or without related paraspinal areas
95863	148.18	106.76	41.42	Needle electromyography; three extremities with or without related paraspinal areas
95864	192.87	113.82	79.05	Needle electromyography; four extremities with or without related paraspinal areas
95867	71.39	45.74	25.65	Needle electromyography; cranial nerve supplied muscle(s), unilateral
95868	98.51	67.50	31.01	Needle electromyography; cranial nerve supplied muscles, bilateral
95869	30.87	21.00	9.87	Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)
95870	30.87	21.00	9.87	Needle electromyography; limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters
95872	111.41	84.62	26.79	Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied
95875	106.32	62.37	43.95	Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)
95900	71.12	24.15	46.97	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study
95903	74.84	34.19	40.65	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study
95904	60.51	19.44	41.07	Nerve conduction, amplitude and latency/velocity study, each nerve; sensory
95920	181.61	124.29	57.32	Intraoperative neurophysiology testing, per hour (List separately in addition to code for primary procedure)
95921	65.25	49.05	16.20	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including two or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio
95922	70.46	54.26	16.20	Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least five minutes of passive tilt
95923	123.42	50.74	72.68	Testing of autonomic nervous system function; sudomotor, including one or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential
95925	70.82	30.66	40.16	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs
95926	71.24	31.08	40.16	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs
95927	72.26	32.10	40.16	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head
95930	74.08	19.82	54.26	Visual evoked potential (VEP) testing central nervous system, checkerboard or flash
95933	68.07	32.97	35.10	Orbicularis oculi (blink) reflex, by electrodiagnostic testing
95934	38.98	29.11	9.87	H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle
95936	41.33	31.46	9.87	H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle
95937	51.42	36.49	14.93	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method
95950	261.26	86.92	174.34	Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours

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95951		341.42		Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours
95953	454.70	174.13	280.57	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours
95954	278.63	140.25	138.38	Pharmacological or physical activation requiring physician attendance during EEG recording of activation phase (eg, thiopental activation test)
95955	143.20	55.06	88.14	Electroencephalogram (EEG) during nonintracranial surgery (eg, carotid surgery)
95956	729.00	174.85	554.15	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours
95957	188.58	112.90	75.68	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)
95958	317.93	240.26	77.67	Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring
95961	231.56	174.24	57.32	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician attendance
95962	243.26	185.94	57.32	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of physician attendance (List separately in addition to code for primary procedure)
95965		456.57		Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)
95966		228.79		Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)
95967		192.47		Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)
95970	25.34			Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming
95971	43.32			Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple brain, spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming
95972	87.73			Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour
95973	53.53			Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain, spinal cord, or peripheral (except cranial nerve)

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				neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)
95974	172.91			Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour
95975	97.28			Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)
95990	65.03			Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular);
95991	91.12			Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician
95999	I.C.			Unlisted neurological or neuromuscular diagnostic procedure
96000	91.66			Comprehensive computer-based motion analysis by video-taping and 3-D kinematics;
96001	109.50			Comprehensive computer-based motion analysis by video-taping and 3-D kinematics; with dynamic plantar pressure measurements during walking
96002	22.38			Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles
96003	21.05			Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle
96004	123.75			Physician review and interpretation of comprehensive computer based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report
96100	80.01			Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, per hour
96105	80.01			Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
96110	13.41			Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report
96111	148.55			Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report, per hour
96115	80.01			Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour
96117	80.01			Neuropsychological testing battery (eg, Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour
96150	27.46			Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15

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				minutes face-to-face with the patient; initial assessment
96151	26.29			Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment
96152	25.11			Health and behavior intervention, each 15 minutes, face-to-face; individual
96153	5.76			Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)
96154	24.74			Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)
96155	24.78			Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)
96400	53.92			Chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia
96405	119.27			Chemotherapy administration, intralesional; up to and including 7 lesions
96406	161.45			Chemotherapy administration, intralesional; more than 7 lesions
96408	130.88			Chemotherapy administration, intravenous; push technique
96410	184.17			Chemotherapy administration, intravenous; infusion technique, up to one hour
96412	39.70			Chemotherapy administration, intravenous; infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)
96414	228.85			Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
96420	127.26			Chemotherapy administration, intra-arterial; push technique
96422	227.59			Chemotherapy administration, intra-arterial; infusion technique, up to one hour
96423	89.63			Chemotherapy administration, intra-arterial; infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)
96425	208.20			Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
96440	448.51			Chemotherapy administration into pleural cavity, requiring and including thoracentesis
96445	445.36			Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis
96450	381.94			Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture
96520	174.30			Refilling and maintenance of portable pump
96530	128.77			Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)
96542	242.09			Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents
96545	I.C.			Provision of chemotherapy agent
96549	I.C.			Unlisted chemotherapy procedure
96567	42.51			Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session
96570	58.58			Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)

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96571	29.77			Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)
96900	20.83			Actinotherapy (ultraviolet light)
96902	26.30			Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality
96910	46.30			Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B
96912	57.99			Photochemotherapy; psoralens and ultraviolet A (PUVA)
96913	78.03			Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least four to eight hours of care under direct supervision of the physician (includes application of medication and dressings)
96920	369.99			Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm
96921	373.69			Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm
96922	442.35			Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm
96999	I.C.			Unlisted special dermatological service or procedure
97802	20.11			Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	20.11			Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	8.31			Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes
98925	31.18			Osteopathic manipulative treatment (OMT); one to two body regions involved
98926	42.82			Osteopathic manipulative treatment (OMT); three to four body regions involved
98927	55.51			Osteopathic manipulative treatment (OMT); five to six body regions involved
98928	65.33			Osteopathic manipulative treatment (OMT); seven to eight body regions involved
98929	75.04			Osteopathic manipulative treatment (OMT); nine to ten body regions involved
98943	25.50			Chiropractic manipulative treatment (CMT); extraspinal, one or more regions
99000	I.C.			Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory
99001	I.C.			Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated)
99002	I.C.			Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (eg, designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics, protectives, prosthetics are fabricated by an outside laboratory or shop but which items have been designed, and are to be fitted and adjusted by the attending physician
99024	I.C.			Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure
99026	I.C.			Hospital mandated on call service; in-hospital, each hour
99027	I.C.			Hospital mandated on call service; out-of-hospital, each hour
99050	I.C.			Services requested after posted office hours in addition to basic service
99052	I.C.			Services requested between 10:00 PM and 8:00 AM in addition to basic service

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99054	I.C.			Services requested on Sundays and holidays in addition to basic service
99056	I.C.			Services provided at request of patient in a location other than physician's office which are normally provided in the office
99058	I.C.			Office services provided on an emergency basis
99070	I.C.			Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
99071	I.C.			Educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician
99075	I.C.			Medical testimony
99078	I.C.			Physician educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)
99080	24.85			Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. (An additional report that is completed at the request of the patient's employer, insurer, utilization reviewer or agent subsequent to the completion of the required report under 452 CMR 1.13(1). This fee is for the treating provider's preparation time only. (per 15 minutes)) (Do not report 99080 in conjunction with codes using modifier -32 or with 99455, 99456 for the completion of Workmen's Compensation forms)
99082	I.C.			Unusual travel (eg, transportation and escort of patient)
99090	I.C.			Analysis of clinical data stored in computers (eg, ECGs, blood pressures, hematologic data)
99091	I.C.			Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time
99100	I.C.			Anesthesia for patient of extreme age, under 1 year and over 70 (List separately in addition to code for primary anesthesia procedure)
99116	I.C.			Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)
99135	I.C.			Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)
99140	I.C.			Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)
99141	112.60			Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation
99142	65.56			Sedation with or without analgesia (conscious sedation); oral, rectal and/or intranasal
99170	140.90			Anogenital examination with colposcopic magnification in childhood for suspected trauma
99172	I.C.			Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determination(s) for contrast sensitivity, vision under glare)
99173	I.C.			Screening test of visual acuity, quantitative, bilateral
99175	62.01			Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison
99183	292.67			Physician attendance and supervision of hyperbaric oxygen therapy, per session
99185	28.18			Hypothermia; regional

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99186	88.95			Hypothermia; total body
99190	I.C.			Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); each hour
99191	I.C.			Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); 3/4 hour
99192	I.C.			Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); 1/2 hour
99195	19.15			Phlebotomy, therapeutic (separate procedure)
99199	I.C.			Unlisted special service, procedure or report
99201	38.65			Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99202	68.29			Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99203	101.16			Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99204	142.67			Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99205	180.76			Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99211	23.15			Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	40.33			Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making.

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				Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99213	55.97			Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	87.24			Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99215	125.63			Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99217	72.41			Observation care discharge day management (This code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])
99218	68.19			Initial observation care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity.
99219	114.05			Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity.
99220	160.07			Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity.
99221	69.04			Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of

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				low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.
99222	114.89			Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.
99223	160.19			Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.
99231	34.43			Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.
99232	56.77			Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.
99233	80.66			Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.
99234	142.59			Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity.
99235	187.77			Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and

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				the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity.
99236	233.97			Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity.
99238	72.53			Hospital discharge day management; 30 minutes or less
99239	98.99			Hospital discharge day management; more than 30 minutes
99241	53.03			Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99242	96.21			Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99243	127.05			Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99244	179.23			Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99245	231.20			Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.
99251	36.93			Initial inpatient consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.
99252	73.85			Initial inpatient consultation for a new or established patient, which requires these three

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				key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.
99253	100.60			Initial inpatient consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.
99254	145.19			Initial inpatient consultation for a new or established patient, which requires three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.
99255	199.57			Initial inpatient consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.
99261	23.18			Follow-up inpatient consultation for an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's hospital floor or unit.
99262	46.32			Follow-up inpatient consultation for an established patient which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.
99263	68.36			Follow-up inpatient consultation for an established patient which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.
99271	41.35			Confirmatory consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and

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				the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
99272	68.34			Confirmatory consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity.
99273	93.64			Confirmatory consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99274	125.87			Confirmatory consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity.
99275	159.84			Confirmatory consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity.
99281	16.84			Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
99282	28.26			Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
99283	62.83			Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99284	97.55			Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99285	152.64			Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: a comprehensive history; a

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				comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99288	I.C.			Physician direction of emergency medical systems (EMS) emergency care, advanced life support
99289	266.25			Critical care services delivered by a physician, face-to-face, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or less; first 30-74 minutes of hands on care during transport
99290	127.89			Critical care services delivered by a physician, face-to-face, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or less; each additional 30 minutes (List separately in addition to code for primary service)
99291	254.20			Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	111.96			Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
99293	836.89			Initial inpatient pediatric critical care, 31 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child
99294	414.67			Subsequent inpatient pediatric critical care, 31 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child
99295	948.54			Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 30 days of age or less Care for neonates who require an intensive care setting but who are not critically ill is reported using the initial hospital care codes (99221-99223).
99296	417.20			Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 30 days of age or less
99298	146.51			Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)
99299	137.92			Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)
99301	75.00			Evaluation and management of a new or established patient involving an annual nursing facility assessment which requires these three key components: a detailed interval history; a comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. The review and affirmation of the medical plan of care is required. Physicians typically spend 30 minutes at the bedside and on the patient's facility floor or unit.
99302	102.56			Evaluation and management of a new or established patient involving a nursing facility assessment which requires these three key components: a detailed interval history; a comprehensive examination; and medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem and has had a major permanent change in status. The creation of a new medical plan of care is required. Physicians typically spend 40 minutes at the bedside and on the patient's facility floor or unit.
99303	126.80			Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility, which requires these three key components: a comprehensive history; a comprehensive examination;

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				and medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The creation of a medical plan of care is required. Physicians typically spend 50 minutes at the bedside and on the patient's facility floor or unit.
99311	43.04			Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.
99312	66.31			Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.
99313	90.46			Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.
99315	73.62			Nursing facility discharge day management; 30 minutes or less
99316	96.30			Nursing facility discharge day management; more than 30 minutes
99321	42.13			Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: a problem focused history; a problem focused examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity.
99322	58.68			Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99323	72.95			Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high complexity.
99331	36.72			Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is

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				straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving.
99332	47.39			Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication.
99333	57.88			Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem.
99341	60.12			Home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99342	87.78			Home visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99343	128.05			Home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99344	167.60			Home visit for the evaluation and management of a new patient, which requires these three components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99345	207.45			Home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes face-to-face with the patient and/or family.
99347	46.30			Home visit for the evaluation and management of an established patient, which requires

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				at least two of these three key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99348	78.94			Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99349	122.11			Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99350	176.88			Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99354	100.46			Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (eg, prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)
99355	99.62			Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (eg, prolonged care and treatment of an acute asthmatic patient in an outpatient setting); each additional 30 minutes (List separately in addition to code for prolonged physician service)
99356	92.72			Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); first hour (List separately in addition to code for inpatient Evaluation and Management service)
99357	93.14			Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); each additional 30 minutes (List separately in addition to code for prolonged physician service)
99358	I.C.			Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (eg, review of extensive records and tests, communication with other professionals and/or the patient/family); first hour (List separately in addition to code(s) for other physician service(s) and/or inpatient or outpatient Evaluation and Management service)

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99359	I.C.			Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (eg, review of extensive records and tests, communication with other professionals and/or the patient/family); each additional 30 minutes (List separately in addition to code for prolonged physician service)
99360	I.C.			Physician standby service, requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)
99361	I.C.			Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes
99362	I.C.			Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 60 minutes
99371	24.85			Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (eg, to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 15 minutes.)
99372	49.70			Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); intermediate (eg, to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 30 minutes.)
99373	74.55			Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); complex or lengthy (eg, lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 45 minutes.)
99374	72.49			Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99375	132.68			Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring

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				complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more
99377	72.49			Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99378	149.12			Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more
99379	72.19			Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99380	109.19			Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more
99381	109.61			Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; infant (age under 1 year)
99382	117.70			Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
99383	115.17			Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; late childhood (age 5

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				through 11 years)
99384	124.83			Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	124.83			Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years
99386	146.34			Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 40-64 years
99387	158.61			Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 65 years and over
99391	82.66			Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; infant (age under 1 year)
99392	92.32			Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
99393	91.06			Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	100.42			Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	101.68			Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 18-39 years
99396	112.19			Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 40-64 years
99397	123.61			Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 65

Code	GL Fee	Fee PC	Fee TC	40.06(10) – Medical Service Description
				years and over
99401	44.54			Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	74.23			Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	102.20			Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	130.68			Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99411	13.54			Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412	20.27			Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes
99420	I.C.			Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal)
99429	I.C.			Unlisted preventive medicine service
99431	61.64			History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records. (This code should also be used for birthing room deliveries.)
99432	87.55			Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s)
99433	32.41			Subsequent hospital care, for the evaluation and management of a normal newborn, per day
99435	79.44			History and examination of the normal newborn infant, including the preparation of medical records. (This code should only be used for newborns assessed and discharged from the hospital or birthing room on the same date.)
99436	77.76			Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn
99440	154.01			Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output
99450	I.C.			Basic life and/or disability examination that includes: measurement of height, weight and blood pressure; completion of a medical history following a life insurance pro forma; collection of blood sample and/or urinalysis complying with "chain of custody" protocols; and completion of necessary documentation/certificates.
99455	I.C.			Work related or medical disability examination by the treating physician that includes: completion of a medical history commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report.
99456	I.C.			Work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report.
99499	I.C.			Unlisted evaluation and management service
99500	I.C.			Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring

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99501	I.C.			Home visit for postnatal assessment and follow-up care
99502	I.C.			Home visit for newborn care and assessment
99503	I.C.			Home visit for respiratory therapy care (eg, bronchodilator, oxygen therapy, respiratory assessment, apnea evaluation)
99504	I.C.			Home visit for mechanical ventilation care
99505	I.C.			Home visit for stoma care and maintenance including colostomy and cystostomy
99506	I.C.			Home visit for intramuscular injections
99507	I.C.			Home visit for care and maintenance of catheter(s) (eg, urinary, drainage, and enteral)
99509	I.C.			Home visit for assistance with activities of daily living and personal care
99510	I.C.			Home visit for individual, family, or marriage counseling
99511	I.C.			Home visit for fecal impaction management and enema administration
99512	I.C.			Home visit for hemodialysis
99600	I.C.			Unlisted home visit service or procedure
99601	I.C.			Home infusion/specialty drug administration, per visit (up to 2 hours);
99602	I.C.			Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure)

40.06(11) Psychological Services

Code	Fee	40.06(11) – Psychological Services Description
90801	122.91	Psychiatric diagnostic interview examination
90804	52.93	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;
90805	57.99	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90806	79.33	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;
90807	84.30	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90808	118.46	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;
90809	122.20	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
90816	53.12	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;
90817	57.52	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90818	79.89	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;
90819	83.54	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90821	118.74	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;
90822	121.73	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
90847	93.89	Family psychotherapy (conjoint psychotherapy) (with patient present)
90853	25.95	Group psychotherapy (other than of a multiple-family group)
90857	29.02	Interactive group psychotherapy
90882	I.C.	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
90885	41.39	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes
90887	71.83	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
90889	24.78	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers (An additional report that is completed at the request of the patient’s employer, insurer, utilization reviewer or agent subsequent to the completion of the required report under 452 CMR 1.13(1). This fee is for the treating provider’s preparation time only. (per 15 minutes)) (Do not report 90889 in conjunction with codes using modifier -32 or with 99455, 99456 for the completion of Workmen’s Compensation forms)

Code	Fee	40.06(11) – Psychological Services Description
96100	62.75	Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, per hour
96105	62.75	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
96115	62.75	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour
96117	62.75	Neuropsychological testing battery (eg, Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour
96150	21.54	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment
96151	20.62	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment
96152	19.70	Health and behavior intervention, each 15 minutes, face-to-face; individual
96153	4.52	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)
96154	19.40	Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)
99371	24.85	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (eg, to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 15 minutes.)
99372	49.70	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); intermediate (eg, to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 30 minutes.)
99373	74.55	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); complex or lengthy (eg, lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 45 minutes.)
H2011	I.C.	Crisis intervention service, per 15 minutes

40.06(12) Rehabilitation Clinics, Physical, Occupational, Speech Therapists and Audiologists

Code	Fee	40.06(12) – Restorative Services Description
92506	107.80	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
92507	50.80	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
92508	23.98	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two or more individuals
92511	123.74	Nasopharyngoscopy with endoscope (separate procedure)
92512	50.07	Nasal function studies (eg, rhinomanometry)
92516	40.69	Facial nerve function studies (eg, electroneuronography)
92520	38.14	Laryngeal function studies
92526	68.38	Treatment of swallowing dysfunction and/or oral function for feeding
97001	58.28	Physical therapy evaluation
97002	30.97	Physical therapy re-evaluation
97003	62.38	Occupational therapy evaluation
97004	36.33	Occupational therapy re-evaluation
97012	11.70	Application of a modality to one or more areas; traction, mechanical
97014	11.31	Application of a modality to one or more areas; electrical stimulation (unattended)
97016	11.31	Application of a modality to one or more areas; vasopneumatic devices
97018	5.39	Application of a modality to one or more areas; paraffin bath
97020	3.81	Application of a modality to one or more areas; microwave
97022	11.97	Application of a modality to one or more areas; whirlpool
97024	4.76	Application of a modality to one or more areas; diathermy
97026	3.81	Application of a modality to one or more areas; infrared
97028	4.69	Application of a modality to one or more areas; ultraviolet
97032	12.34	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	16.63	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	11.21	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	9.63	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	18.55	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97039	9.03	Unlisted modality (specify type and time if constant attendance)
97110	22.44	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	22.63	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	25.95	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	19.32	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	17.37	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97139	12.47	Unlisted therapeutic procedure (specify)
97140	20.80	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	13.76	Therapeutic procedure(s), group (2 or more individuals)
97504	24.02	Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk, each 15 minutes

Code	Fee	40.06(12) – Restorative Services Description
97520	22.00	Prosthetic training, upper and/or lower extremities, each 15 minutes
97530	22.98	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97532	19.28	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
97533	20.23	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97535	23.57	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes
97537	21.46	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes
97542	21.77	Wheelchair management/propulsion training, each 15 minutes
97545	24.20	Work hardening/conditioning; initial 2 hours
97601	30.71	Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (eg, high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
97602	I.C.	Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
97703	20.45	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
97750	22.63	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes
97755	27.11	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes
99080	24.85	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. (An additional report that is completed at the request of the patient's employer, insurer, utilization reviewer or agent subsequent to the completion of the required report under 452 CMR 1.13(1). This fee is for the treating provider's preparation time only. (per 15 minutes)) (Do not report 99080 in conjunction with codes using modifier -32 or with 99455, 99456 for the completion of Workmen's Compensation forms)
99371	24.85	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (eg, to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 15 minutes.)
99372	49.70	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); intermediate (eg, to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 30 minutes.)
99373	74.55	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); complex or lengthy (eg, lengthy counseling session with anxious or distraught

Code	Fee	40.06(12) – Restorative Services Description
		patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan) (Treatment planning consultation with patient's employer, insurer, utilization reviewer or agent for the purpose of obtaining additional medical information subsequent to the completion of the required report under 452 CMR 1.13(1). Per 45 minutes.)
G0237	15.29	Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring)

40.07: Appendices

APPENDIX	DESCRIPTION	PAGE NUMBER
A	CPT and HCPCS Modifiers. Add the appropriate Level 1 CPT modifier to the five digit code or identify the modifier by use of a separate code by adding 099 before the 2 digit number e.g. 09950, 09951.	
B	Add-On Codes – Procedures that are commonly carried out in addition to the primary procedure performed and must never be reported as stand-alone codes. These codes are exempt from the multiple modifier '51'.	
C	Separate Procedures - Procedures that are stand alone codes. These codes are exempt from the multiple modifier '51'.	
D	Drugs Administered Other Than Oral Method – List of drugs and biologicals that can be injected either subcutaneously, intramuscularly, or intravenously reimbursed at invoice cost.	

(1). **APPENDIX A –** Level I and Level II Common Modifiers

(a) Anesthesia Modifiers

1. Physical Status Modifiers. Physical status modifying units will be reimbursed if the patient is ranked in one of the following three categories. Physical status is included in CPT to distinguish various levels of complexity of the anesthesia service provided. Example: 00100-P3

Physical Status Modifiers	Description	Modifying Unit Value
P3	A patient with severe systemic disease.	1
P4	A patient with severe systemic disease that is a constant threat to life.	2
P5	A moribund patient who is not expected to survive without the operation.	3

2. CPT and HCPCS Modifiers for Anesthesia Services. Add the appropriate Level 1 CPT modifier or HCPCS Level II modifier to the five digit code or identify the modifier by use of a separate code by adding 099 before the 2 digit number e.g. 09950, 09951.

Level 1 CPT Modifier	Description
-23 Unusual Anesthesia	Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier '-23' to the procedure code of the basic service or by use of the separate five digit modifier code 09923.
-47Anesthesia by Surgeon	Regional or general anesthesia provided by the surgeon may be reported by adding the modifier '-47' to the basic service or by use of the separate five digit modifier code 09947. (This does not include local anesthesia.) Note: Modifier '–47' or 09947 would not be used as a modifier for the anesthesia procedures 00100-01999.
-51 Multiple Procedures	This modifier must be used to report multiple procedures performed at the same session. The service code for the major procedure or service must be reported without a modifier. The secondary, additional or lesser procedure(s) must be identified by adding the modifier '51' to the end of the service code for the secondary procedure(s). Note: This modifier should not be used with designated "add-on" codes or with codes in which the narrative begins with "each additional." (See Appendix B)
-QK Medical Direction of Multiple Anesthesia Procedures	This modifier must be used in conjunction with the appropriate service code to denote medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
-QX CRNA Service	This modifier must be used to report services of a CRNA: with medical direction by a physician. This medical direction modifier is used when the physician medically directs two, three, or four concurrent procedures involving interns, residents, CRNAs and AAs. This allows 50% of the fee to be paid to the employer.
-QY CRNA Service	This modifier must be used to report services of one CRNA: with medical direction by an anesthesiologist. This allows 100% of the fee to be paid to the employer.
-QZ CRNA Service	This modifier is used to report CRNA service: without medical direction by a physician. This allows 100% of the fee to be paid to the employer.

(b) CPT Modifiers for Clinical Laboratory Services. Add the appropriate Level 1 or Level II CPT modifier to the five digit code or identify the modifier by use of a separate code by adding 099 before the 2 digit number e.g. 09950, 09951.

Level 1 Modifier	Description
-59 Distinct Procedural Service	The modifier –59 is appropriate to report multiple service submissions for the same patient on the same day. These situations usually involve microbiology where samples or cultures are taken from a patient from different anatomical sites or different wounds, use the same CPT code, and then are tested the same day.

Level 1 Modifier	Description
-90 Reference (Outside) Laboratory	When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '-90' to the usual procedure number or by use of the separate five digit modifier code 09990.
-91 Repeat Clinical Diagnostic Laboratory Service	The modifier –91 is used if an ordering physician requests a laboratory test that requires that several of the same services (CPT code) be performed for the same patient on the same day, modifier –91 should be used to indicate that multiple clinical diagnostic laboratory tests were done on the same day. (This modifier should not be used when multiple tests are described under a single code, e.g. glucose tolerance test.)

(c) HCPCS Modifiers for Durable Medical Equipment, Oxygen Delivery and Orthotic and Prosthetic Procedure Codes. Add the appropriate Level II HCPCS modifier to the five-digit code to identify the specific circumstance.

Level II Modifier	Description
-KH	DMEPOS item, initial claim, purchase or first month rental
-KI	DMEPOS item, second or third month rental
-KJ	DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months 4 to 15
-KM	Replacement of facial prosthesis including new impression/moulage
-KN	Replacement of facial prosthesis using previous master model
-KR	Rental Item, billing for partial month
-LL	Lease/Rental with option to purchase (use the 'LL'modifier when DME equipment rental is to be applied against the purchase price)
-MS	Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty
-NR	New when rented (use the 'NR' modifier when DME which was new at the time of rental is subsequently purchased)
-NU	New equipment
-QE	Modifier QE should be used in conjunction with the appropriate service code to denote oxygen liter flow that is less than one liter per minute (LPM). This shall be reimbursed at 50% of the published rate of the appropriate service code.
-QF	Modifier QF should be used in conjunction with the appropriate service code to denote a stationary oxygen unit (liquid) with flow greater than four liters per minute (LPM). This shall be reimbursed at 150% of the published rate of the appropriate service code.
-QG	Modifier QG shall be used in conjunction with the appropriate service code to denote the use of a gaseous oxygen cylinder (H or M) with flow greater than four liters per minute (LPM). This shall be reimbursed at 150% of the published rate of the appropriate service code.
-RP	Replacement and repair –RP may be used to indicate replacement of DME, orthotic and prosthetic devices which have been in use for sometime. The claim shows the code for the part, followed by the '-RP' modifier and the charge for the part
-RR	Rental (use the 'RR' modifier when DME is to be rented)
-UE	Used Durable Medical Equipment

(d) CPT and HCPCS Modifiers for Physicians' Services. Add the appropriate Level 1 CPT modifier or HCPCS Level II modifier to the five digit code or identify the modifier by use of a separate code by adding 099 before the 2 digit number e.g. 09950, 09951.

Level 1 CPT Modifier	Description
-21 Prolonged Evaluation and Management Services	When the face to face or floor/unit services(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier '-21' to the evaluation and management code number or by use of the separate five digit modifier code 09921.

Level 1 CPT Modifier	Description
	A report may also be appropriate
-22 Unusual Procedural Service	When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '-22' to the usual procedure number or by use of the separate five digit modifier code 09922. A report may also be appropriate
-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service	The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date, This circumstance may be reported by adding the modifier '-25' to the appropriate level of E/M service, or the separate five digit modifier 09925 may be used. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier '-57.'
-26 Professional Component (PC)	Certain procedures are a combination of a physician, or professional component, and a technical component. When the modifier –26 is added to an appropriate code a PC allowable amount shall be paid.
-32 - Mandated Services	Services related to mandated consultation and/or related service (eg. PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier '32' to the basic procedure. [Use modifier -32 in addition to an Evaluation and Management (E/M) code to identify an initial/comprehensive office visit for the purpose of an injury assessment and in-depth evaluation of medical complaint(s) and present injury, past medical history, system review, physical examination, ordering of appropriate tests and procedures, and the preparation of an appropriate report as required under 452 CMR 1.13(1). If a confirmatory consultation is required, eg, by a third party payor, the modifier '-32', mandated services, should also be reported. The addition of modifier -32 to the E/M code allows 115% of the allowable fee listed to be paid to the eligible provider.]
–50 Bilateral Procedures	Unless otherwise identified in the procedure code listing, bilateral procedures that are performed at the same operative session should be identified by adding the modifier '50' to the end of the service code identifying the second bilateral procedure or by use of the separate five digit modifier code 09950. The addition of the modifier '50' to the second bilateral code allows 50% of the allowable fee contained in 114.3 CMR 40.06 to be paid to the eligible provider for the second bilateral procedure.
–51 Multiple Procedures	When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) must be identified by adding the modifier '51' to the end of the service code for the additional procedure(s) or service(s) or by use of the separate five-digit modifier 09951. The addition of the modifier "51" to the second and subsequent procedure code allows 50% of the allowable fee in 114.3 CMR 40.06 to be paid to the eligible provider. Note: This modifier should not be used with designated "add-on" codes or with codes in which the narrative begins with "each additional." (See 114.3 CMR 40.08(2) and 114.3 CMR40.08(3).)
–52 Reduced Service	Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances, the service provided can be identified by its usual procedure number and addition of the modifier "52" signifying the procedure is reduced. The fee will be based on individual consideration.
-54 Pertains to Surgical Care Only.	When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the modifier '54' to the appropriate code. This allows 85% of the allowable fee contained in 114.3 CMR 40.06 to be paid to the physician.
-55 Pertains to Postoperative Management Only	When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier '55' to the appropriate procedure code. This allows 15% of the

Level 1 CPT Modifier	Description
	allowable fee contained in 114.3 CMR 40.06 to be paid to the physician.
–59 Distinct Procedure or Service	If a procedure or service not normally reported together was performed on the same day, the fee will be based on the full maximum fee of 100% of the payment group for the distinct procedure or service.
-62: Pertains to Two Surgeons	Under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. These circumstances may be identified by adding the modifier '-62'to the procedure code used by each surgeon for reporting his services. The addition of the modifier '-62'to the procedure codes allows 57.5% of the allowable fee contained in 114.3 CMR 40.06 to be paid to each surgeon. No separate payment will be made for assisting surgical services in these cases; it is included in the total surgical fee listed.
-66: Pertains to Team Surgery	This modifier must be used to identify highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment) carried out under the "surgical team" concept. The unit fee is payable to the "director" of the surgical team and includes all assistant surgeon fees, there are no separate payments for assisting surgical services. The director of the surgical team is expected to distribute the unit fee to the members of the surgical team. Such procedures are so designated in 114.3 CMR 40.06.
–76 Repeat Procedure by the Same Physician	This modifier indicates a procedure that is repeated by the same physician.
–77 Repeat Procedure by Another Physician	This modifier indicates a repeated procedure by another physician.
–78 Return to the Operating Room for a Related Procedure During the Postoperative Period	This modifier indicates a procedure related to the initial procedure during the postoperative period.
–79 Unrelated Procedure or Service by the Same Physician during the Postoperative Period.	When the same physician performs a procedure, unrelated to the initial procedure, during the postoperative period.
-80: Pertains to Assistant Surgeons	Surgical assistant services may be identified by adding the modifier '-80' to the usual procedure code. This allows 15% of the allowable fee contained in 114.3 CMR 40.06 to be paid to the assistant surgeon.
-81 Minimum Assistant Surgeon.	Minimum surgical assistant services are identified by adding the modifier '-81' to the usual procedure number or by use of the separate five digit modifier code 09981. This allows 15% of the allowable fee contained in 114.3 CMR 40.06 to be paid to the assistant surgeon.
-82 Assistant Surgeon (when qualified resident surgeon not available)	The unavailability of a qualified resident surgeon is a prerequisite for use of modifier '-82' appended to the usual procedure code numbers(s) or by use of the separate five digit modifier code 09982. This allows 15% of the allowable fee contained in 114.3 CMR 40.06 to be paid to the assistant surgeon.
-AS Assistant at Surgery	Add modifier -AS to the surgery procedure code to indicate physician assistants or nurse practitioner services for assistant-at-surgery in addition to modifier –81 when applicable.
-SA Nurse Practitioner	This modifier must be used to report services of a NP: with medical direction by a physician and indicates reduced payment.
-S1 Physician's Assistant	This modifier must be used to report services of a PA: with medical direction by a physician and indicates reduced payment.
-SM Second Option	This modifier is used to indicate a second surgical opinion.
-SN Third Option	This modifier is used to indicate a third surgical opinion.

(2) **Appendix B** – Add-On Codes

Summary of CPT Add-On Codes for CPT 2004

CODE
01953
01968
01969
11001
11101
11201
11732
11922
13102
13122
13133
13153
15001
15101
15121
15201
15221
15241
15261
15343
15351
15401
15787
16036
17003
17310
19001
19126
19291
19295
22103
22116
22216
22226
22328
22522
22534
22585
22614
22632
26125
26861
26863
27358
27692
31632

31633
32501
33141
33225
33508
33530
33572
33924
33961
34808
34813
34826
35390
35400
35500
35572
35681
35682
35683
35685
35686
35697
35700
36218
36248
37206
37208
37250
37251
38102
38746
38747
43635
44015
44121
44128
44139
44203
44701
44955
47001
47550
48400
49568
49905
56606
54834

58611
59525
60512
61316
61517
61609
61610
61611
61612
61795
61864
61868
62148
62160
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63103
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76083
76125
76802
76810
76812
76937
78020
78478
78480
78496
87187
87904
88141
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96412
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99602

(3). **APPENDIX C Codes Exempt from Modifier –51**

Summary of CPT Separate Procedure Codes Exempt from Modifier –51 for CPT 2004

CODE
17004
17304
17305
17306
17307
20660
20690
20692
20900
20902
20910
20912
20920
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20930
20931
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20938
20974
20975
22840
22841
22842
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22847
22848
22851
31500
32000
32002
32020
33517
33518
33519
33521
33522
33523
35600

36620
36660
38792
44500
61107
61210
62284
90281
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(3) **Appendix D** Drugs Administered Other Than Oral Method

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40.08: Severability

The provisions of 114.3 CMR 40.00 are severable. If any provision of 114.3 CMR 40.00 or the application of such provision to eligible providers of services or any circumstances should be held invalid or unconstitutional, such determination shall not be construed to affect the validity or constitutionality of any other provision of 114.3 CMR 40.00 or the application of any other provision.